

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. LENGTH OF STAY IN 1b <u>Snow Hill</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u> | | d. STREET ADDRESS <u>107 Bell St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>John</u> First <u>EDWARD</u> Middle <u>ADKINS</u> Last | | 4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>67</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 9, 1907</u> |
| 9. AGE (In years lost birthday) <u>60</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief of Police</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Town Police Dept.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Snow Hill Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>John H. Adkins</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Rosa Cooper</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <u>213 01 7560</u> | | 17. INFORMANT <u>Gregg Cash, Snow Hill, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4231 Ventricular aneurysm</u> DUE TO (b) <u>ASCVD. suspected.</u> DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11-25</u> , 19 <u>67</u> , to <u>12-9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-9</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Joseph C. Fitzgerald</u> | | 22b. DATE SIGNED <u>12/12/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Joseph C. Fitzgerald</u> | | 22d. ADDRESS <u>Medical Center Salisbury Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>12-13-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Whiteoak Methodist</u> | 23d. LOCATION (City or Town) (County) (State) <u>Snow Hill Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Ernest F. Adams, Snow Hill, Md.</u> | | 25a. REC'D BY REGISTRAR DATE <u>DEC 15 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

EXHIBIT OF DEED

12345

1000000

1000000

X



RECEIVED
OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C. 20315-5000
JAN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 17780

| | | | | | | | |
|---|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 9 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | | | d. STREET ADDRESS Route #6, Allen Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First LANKFORD Middle MUERL Last ANDERSON | | | | 4. DATE OF DEATH Month December Day 26 Year 19 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH October 28, 1907 | 9. AGE (In years last birthday) 60 yrs. | | IF UNDER 1 YEAR Months 22 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Bivalve, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Walter Anderson | | | | 14. MOTHER'S MAIDEN NAME Iva Horseman | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes | | 16. SOCIAL SECURITY NO. 220-01-9335 | | 17. INFORMANT Mrs. Pauline E. Anderson (Wife) Rt. #6, Allen Drive, Salisbury, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/6, 1967 to 12/26, 1967 , that (I) (we) last saw the deceased alive on Dec 26, 1967 , and that death occurred at _____ M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE David J. Gilmore | | | | 22b. DATE SIGNED December 28/1967 | | 22c. PHYSICIAN'S NAME (Type) David J. Gilmore | |
| 22d. ADDRESS Medical Center, Salisbury, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF December 28, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Mardela Memorial Cemetery | | 23d. LOCATION (City, town or county) (State) Mardela, Maryland | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | | | 25a. REC'D BY REGISTRAR DEC 29 1967 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

17775

DEPARTMENT OF THE ARMY

17775

NAME: [illegible]
RANK: [illegible]
COMPANY: [illegible]
REGIMENT: [illegible]
BATTALION: [illegible]
BRANCH: [illegible]
DIVISION: [illegible]
CORPS: [illegible]
ARMY: [illegible]
UNIT: [illegible]
GRADE: [illegible]
SERIAL: [illegible]
DATE: [illegible]
PLACE: [illegible]
REMARKS: [illegible]

20-11-335

Wm. E. Anderson (1st)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17781

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | c. LENGTH OF STAY IN 1b 3Mos.-5Days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Powellville | | | 22-1 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital | | | | d. STREET ADDRESS --- | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Fannie Middle Martha Last Baker | | | | 4. DATE OF DEATH Month December Day 1 Year 19 67 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH June 11, 1886 | | 9. AGE (In years last birthday) 81 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME L. Timothy Rayne | | | | 14. MOTHER'S MAIDEN NAME Hennie Martha Lewis | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-10-9925B | | 17. INFORMANT Mr. Horace Baker (Husband) Powellville, Md. Hospital Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebro-vascular Accident DUE TO (c) Arteriosclerotic Heart Disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 Days 3 Days Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis & Metrol & Aortic Stenosis & Negurgitation | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 8/28/67 , 19__, to 12/1/67 , 19__, that (I) (we) last saw the deceased alive on 12/1/67 , 19__, and that death occurred at 9:30M , from causes and on the date stated above. | | 22a. SIGNATURE A. C. Mitchell | |
| 22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M.D. | | 22d. ADDRESS Box 2018, Salisbury, Maryland-21801 | | 22b. DATE SIGNED 12/2/67 | | 22e. MED. PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 5, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery | | 23d. LOCATION (City or Town) (County) (State) Powellville, Wic. Co., Md. | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | | | 25a. REC'D BY REGISTRAR DEC 7 1967 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2000

0010-1328/97/0005-0000\$10.00/0

0.000000

— 2 —

• 15 April 20 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

17778

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17782

| | | | | | |
|--|------------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 2 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital | | | d. STREET ADDRESS Route # 3 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Fannie Middle Mae Last Barber | | | 4. DATE OF DEATH Month Dec. Day 21 Year 19 67 | | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-18-23 | | 9. AGE (In years last birthday) 44 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) N.E. | |
| 13. FATHER'S NAME Dempey Fisher | | | 14. MOTHER'S MAIDEN NAME Edith Wilson | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Betty Boulden Address 109 Edgewood Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Right Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 19 , 19 67 , to Dec. 21 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 21 , 19 67 , and that death occurred at 12:35 P.M. from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE L. V. Maldve | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 12/21/67 | |
| 22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. | | 22d. ADDRESS Deer's Head Hospital; Salisbury, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-27-67 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | |
| 23d. LOCATION (City or Town) (County) (State) Balto. Md. | | 24. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St. | | | |
| 25a. REC'D BY REGISTRAR DEC 27 1967 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

12777

12777

STATEMENT OF WORK

TO THE DIRECTOR, BUREAU OF LAND MANAGEMENT
FROM THE CHIEF, [illegible]
SUBJECT: [illegible]
DATE: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a detailed report or statement of work.]



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|---------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN b 9 Months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS Princess Anne Route # 3 Box 497 | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Clayton Lamont Beckett | | 4. DATE OF DEATH Month Day Year 12-12-67 19 67 | |
| 5. SEX M | 6. COLOR OR RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-12-67 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Dennis | | 14. MOTHER'S MAIDEN NAME Bertha Cannon Beckett | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Bertha Cannon, Princess Anne, Md | | 18. MEDICAL CERTIFICATION | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right subdural hemorrhage 902.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH Hours |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from chair and struck head. | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 12-12-67 A.M. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> Own home | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Princess Anne Somerset Md | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Earl L. Royer, M.D. | | 22. DATE SIGNED 12-14-67 | |
| EXAMINER'S NAME (Type) Earl L. Royer, M.D. | | Address (Street, city, town, or county) 409 Camden Ave. Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/16/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY St Charles | | 23d. LOCATION (City or Town) (County) (State) Chance Somerset, Md | |
| 24. FUNERAL DIRECTOR William James Jr | | Address Princess Anne, Md. | |
| 25a. REC'D BY REGISTRAR DEC 18 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

1777

1777

1777

1777

1777

1777

1777

1777

1777

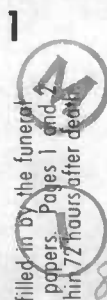
1777

1777

1777

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



177780

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 8 hrs. 51 mins. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield | | d. STREET ADDRESS Peyton Road | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First (Infant) Middle NORMA Last BETTS | | 4. DATE OF DEATH Month DECEMBER Day 25 Year 1967 | |
| 5. SEX FEMALE | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 25, 1967 |
| 9. AGE (In years last birthday) 0 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 8 Min. 51 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----- | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 11. BIRTHPLACE (County & State, or foreign country) Salisbury-Wicomico-Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Jerry Lawson | | 14. MOTHER'S MAIDEN NAME Norma Mister | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. ----- | |
| 17. INFORMANT Clifton Mister | | Address -RFD Peyton Rd.-Crisfield, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH 8 hr. 49 min. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Delivery by C. Sec. due to Abruptio Placenta | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/25, 1967 , to 12/25, 1967 , that (I) (we) last saw the deceased alive on 12/25, 1967 , and that death occurred at 5:05 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Whiterson | | 22b. DATE SIGNED 12/25/67 | |
| 22c. PHYSICIAN'S NAME (Type) Daniel G. Anderson, M.D. | | 22d. ADDRESS Medical Center Bldg. -Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 26, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery | | 23d. LOCATION (City or Town) (County) (State) Crisfield, Md. (Somerset) | |
| 24. FUNERAL DIRECTOR Levin R. Wilson - Somerset County, Md. | | 25a. REC'D BY REGISTRAR DATE JAN 2 1968 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

11770

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|---------------|--|
| Name of Deceased | | Date of Death | |
| Betty | | Jan. 21, 1967 | |
| Age | | 38 | |
| Sex | | Female | |
| Race | | White | |
| Marital Status | | Married | |
| Cause of Death | | Heart Disease | |
| Place of Death | | Home | |
| Signature of Physician | | [Signature] | |
| Signature of Registrar | | [Signature] | |
| Date of Registration | | Jan. 21, 1967 | |
| Place of Registration | | [Location] | |

17781

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17785

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 23 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne | | d. STREET ADDRESS Rt. #1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) LESTER IRVING BLOODSWORTH | | 4. DATE OF DEATH Month 12 Day 28 Year 19 67 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 31, 1883 |
| 9. AGE (In years last birthday) 84 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) MT. VERNON, MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME GEORGE BLOODSWORTH | | 14. MOTHER'S MAIDEN NAME MARY JONES | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT MR. DENWOOD BLOODSWORTH | | Address PR. ANNE, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 3 days Years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Azotemia | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 5, 19 67 , to December 28 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 28 19 67 , and that death occurred at 9:30 A.M. from causes on and the date stated above. | | | |
| 22a. SIGNATURE C. H. Winnacott | | 22b. DATE SIGNED 12/28/67 | |
| 22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M. D. | | 22d. ADDRESS Deer's Head State Hospital, Salisbury, | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 12/30/1967 | 23c. NAME OF CEMETERY OR CREMATORY SABURY CEMETERY | 23d. LOCATION (City or Town) (County) (State) MT. VERNON, MD. |
| 24. FUNERAL DIRECTOR LEVIN R. WILSON | | ADDRESS PRINCESS ANNE, MD. | |
| 25a. REC'D BY REGISTRAR DATE JAN 2 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

A34
4/18/68

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17786

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN lb 2 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS N. Washington St | |
| 3. NAME OF DECEASED (Type or print) R. BRUCE BLYN | | 4. DATE OF DEATH DECEMBER 25 19 67 | |
| 5. SEX MALE | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAR. 15, 1892 |
| 9. AGE (In years last birthday) 75 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MECHANIC | | 10b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE | |
| 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME MARCUS BLYN | | 14. MOTHER'S MAIDEN NAME HESSE AMES | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 220-32-0434 | |
| 17. INFORMANT TILLIE BLYN | | Address SNOW HILL MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 yrs DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/1 , 19 67 to 12/25 , 19 67 , that (I) (we) last saw the deceased alive on 12/25 , 19 67 , and that death occurred at 9:10 A.M. from causes on and on the date stated above. | | | |
| 22a. SIGNATURE David J. Gilmore | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) DAVID J. GILMORE | | 22d. ADDRESS Medical Center, Salisbury MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 12/28/1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Whitcomb Methodist | | 23d. LOCATION (City or Town) (County) (State) Snow Hill MD. | |
| 24. FUNERAL DIRECTOR Donald C. Brandy | | 25a. REC'D BY REGISTRAR Charles Judge | |
| ADDRESS Snow Hill MD. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |
| DATE DEC 29 1967 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5855

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17787

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY Dorchester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Galestown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Addie W. Brinsfield | | 4. DATE OF DEATH December 25 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 18, 1890 |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Dorchester, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Irvin Wheatley | | 14. MOTHER'S MAIDEN NAME Effie Wheatley | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. W5-36-2233 | |
| 17. INFORMANT Mrs. Ernest Suhr | | Address East New Market, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, Chronic Arthritis, Pernicious Anemia | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 21, 1967 to Dec 25, 1967 , that (I) (we) last saw the deceased alive on Dec 25, 1967 , and that death occurred at 7:45 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Thomas C. Hill Jr. M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED 12-25-67 |
| 22c. PHYSICIAN'S NAME (Type) Thomas C. Hill Jr. | | 22d. ADDRESS Pine Bluff Rd. Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF Dec. 28, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Eldorado | 23d. LOCATION (City or Town) (County) (State) Eldorado Md. |
| 24. FUNERAL DIRECTOR Harman Funeral Home | | ADDRESS Sharytown, Md. | 25a. REC'D BY REGISTRAR JAN 2 1968 |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3

1

17784

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17788

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital | | d. STREET ADDRESS 242 Martin Street | |
| 3. NAME OF DECEASED (Type or print) First Neva Middle Grace Last Brittingham | | 4. DATE OF DEATH Month Dec. Day 18 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 2, 1922 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator | | 10b. KIND OF BUSINESS OR INDUSTRY Sewing Room | 9. AGE (In years lost birthday) 45 yrs. |
| 11. BIRTHPLACE (County & State, or foreign country) Snow Hill, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Levin Brittingham | | 14. MOTHER'S MAIDEN NAME Olla Pusey | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Miss Nellie Brittingham, Snow Hill, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of cervix with wide spread metastasis DUE TO (c) 1 yr. | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 6, 1967 , to Dec. 18, 1967 , that (I) (we) last saw the deceased alive on Dec. 18, 1967 , and that death occurred at 2:50 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE A. C. Mitchell | | 22b. DATE SIGNED 12/18/67 | |
| 22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D. | | 22d. ADDRESS Deer's Head Hospital; Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec. 21/67 | 23c. NAME OF CEMETERY OR CREMATORY Bates Methodist | 23d. LOCATION (City or Town) (County) (State) Snow Hill, Md. |
| 24. FUNERAL DIRECTOR Thomas E. Williams, Snow Hill, Md. | | 25a. REC'D BY REGISTRAR DEC 21 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1978

REMARKS ON DEATH

1978

1978

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Worcester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS 418 Dighton Ave. | |
| 3. NAME OF DECEASED (Type or print) MARtha First Middle Last Brown | | 4. DATE OF DEATH December 1 1967 Month Day Year | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Apr. 4, 1913 |
| 9. AGE (In years last birthday) 54 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Factory | |
| 11. BIRTHPLACE (County & State, or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME Frank Brown | | 14. MOTHER'S MAIDEN NAME Alice Victor | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 219-05-2200 | |
| 17. INFORMANT Elizabeth Payne | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCD DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Left Ventricular Failure | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-1-67 , 19__ to 12-1-67 , 19__, that (I) (we) last saw the deceased alive on 12-1-67 , 19__, and that death occurred at 4:45 M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Joseph C. Fitzgerald | | 22b. DATE SIGNED Dec 1, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Samuel Lawrence | | 22d. ADDRESS New Church, Va. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-9-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Bapt. Cem. | | 23d. LOCATION (City or Town) (County) (State) Snow Hill, Md. Wor. | |
| 24. FUNERAL DIRECTOR Samuel Lawrence | | 25a. REC'D BY REGISTRAR DEC 5 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

13738

13738

RECEIVED

RECEIVED

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

NOV 19 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17786

17790

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS 406 Prince Street | |
| 3. NAME OF DECEASED (Type or print) George Washington Burchette | | 4. DATE OF DEATH DECEMBER 31 1967 | |
| 5. SEX MALE | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 5, 1904 |
| 9. AGE (In years last birthday) 63 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-Brick Mason | | 10b. KIND OF BUSINESS OR INDUSTRY Building | |
| 11. BIRTHPLACE (County & State, or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Emory Burchette | | 14. MOTHER'S MAIDEN NAME Julia Dillard | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 237-03-7259 | |
| 17. INFORMANT Mrs. Roxie Burchette (Wife) | | 18. ADDRESS 406 Prince St., Salisbury, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pulmonary emphysema | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 1967 , to 12/31/67 , that (I) (we) last saw the deceased alive on 12/30 1967 and that death occurred at 9:30 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Dr. E.M. Beardsley | | 22b. DATE-SIGNED 12/31/67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. E.M. Beardsley | | 22d. ADDRESS 207 Maryland Ave., Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Jan. 3, 1968 | 23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park | 23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | 25a. REC'D BY REGISTRAR Jan 4 1968 | |
| | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

17780

STATE OF TEXAS

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

17780

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

17787

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17791

| | | | |
|--|------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Worcester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 23-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS 202 West Martin Street | |
| 3. NAME OF DECEASED (Type or print) First Edith Middle D. Last Byrd | | 4. DATE OF DEATH Month 12 Day 23 Year 67 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-28-1890 |
| 9. AGE (In years last birthday) yrs. 77 | | 10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | |
| 11. BIRTHPLACE (State or foreign country) Somerset County | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Marcellus Dickenson | | 14. MOTHER'S MAIDEN NAME Sarah Davis | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-32-1218 | |
| 17. INFORMANT Mrs. James Onley | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car involved in collision. 20c. TIME OF INJURY Month, Day, Year 8 P.M. 12-23-67 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Snow Hill Rd. 20f. (City or town) (County) (State) Snow Hill Worcester Md | | | INTERVAL BETWEEN ONSET AND DEATH Sudden |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| ACTUAL SIGNATURE Earl L. Royer, M.D. | | 22. DATE SIGNED 12-26-67 | |
| EXAMINER'S NAME (Type) Earl L. Royer, M.D. | | Address (Street, city, town, or county) 409 Garden Ave. Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12-26-67 | |
| 23c. NAME OF CEMETERY OR CREMATOR Whatcoat Cemetery | | 23d. LOCATION (City or Town) (County) (State) Snow Hill Worcester Md. | |
| 24. FUNERAL DIRECTOR Dennis Funeral Home Snow Hill, Md. | | 25a. REC'D BY REGISTRAR DATE DEC 29 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

13782

Associated
Maryland

Snow Hill

Continental General Hospital

Relief

3-25-40

P

Continental

Continental

Continental

200-32-1218

Continental

Continental

Continental

Continental

Continental

Continental

Continental

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> | |
| c. LENGTH OF STAY IN 1b <u>2 days</u> | | d. STREET ADDRESS <u>208 Walnut St.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>LESLIE</u> Middle <u>GRIFFIN</u> Last <u>CALLAHAN</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>19 67</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 24, 1896</u> |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Clothing</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Worcester County, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Henry Wise Callahan</u> | | 14. MOTHER'S MAIDEN NAME <u>Ella Bell</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW 1</u> | | 16. SOCIAL SECURITY NO. <u>219-34-3675</u> | |
| 17. INFORMANT <u>Mrs Robert Westfall, Pocomoke, Md.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic carcinoma</u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>3 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 4, 1967</u> , to <u>December 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>December 6, 1967</u> , and that death occurred on <u>12:30 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>A. C. Mitchell</u> | | 22b. DATE SIGNED <u>12/6/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M.D.</u> | | 22d. ADDRESS <u>Deer's Head State Hospital</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>12-9-1967</u> | 23c. NAME OF CEMETERY OR REMOVAL <u>St. Mary Episcopal</u> | 23d. LOCATION (City or Town) (County) (State) <u>Pocomoke - Wor. - Md.</u> |
| 24. FUNERAL DIRECTOR <u>Robert H. Watson</u> | | 25a. REC'D BY REGISTRAR <u>DEC 12 1967</u> | |
| ADDRESS <u>Pocomoke, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/67

| 17789 | | | | | | | | | | | |
|---|--|--------------------------------------|--|---|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 17793 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | | c. LENGTH OF STAY IN 1b 4 yrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 671 Fitzwater Street | | | | | | d. STREET ADDRESS 671 Fitzwater Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) George Carney | | | | | | 4. DATE OF DEATH 12-31-67 | | | | | |
| 5. SEX M | | 6. COLOR OR RACE C | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan 7 1934 | | 9. AGE (In years last birthday) 33 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab. hour | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) va | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Leon Newbens | | | | | | 14. MOTHER'S MAIDEN NAME Sarah Word Carney | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 228-36-9696 | | 17. INFORMANT Sarah Word | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 982X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Stab wound of left popliteal artery DUE TO (c) _____ | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed behind left knee during domestic quarrel. | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Jan 12-31-67 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) own home | | 20f. (City or town) (County) (State) Salisbury Wicomico Md. | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Earl L. Royer, M.D. | | | | | | 22. DATE SIGNED 1-2-68 | | | | | |
| EXAMINER'S NAME (Type) Ea rl L. Royer, M.D. | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 109 Camden Ave. Salisbury, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Jan 6-68 | | 23c. NAME OF CEMETERY OR CREMATORY Green Acres Cem | | 23d. LOCATION (City or town) (County) (State) Salisbury Wicomico | | | | | |
| 24. FUNERAL DIRECTOR West Jan Home | | | | | | 25a. REC'D BY REGISTRAR DATE JAN 4 1968 | | 25b. REGISTRAR'S SIGNATURE James J. Jones | | | |

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital D.O.A. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle RAY Last CHURCH | | 4. DATE OF DEATH Month December Day 25 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 9, 1942 |
| 9. AGE (In years lost birthday) yrs. 25 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Tender - 2nd Class - Navy | |
| 11. BIRTHPLACE (State or foreign country) Mardela, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Earl Johnson Church | | 14. MOTHER'S MAIDEN NAME Lola Bell Robinson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes | | 16. SOCIAL SECURITY NO. 213-42-0582 | |
| 17. INFORMANT Mrs. Ann M. Church (Wife) Address 1210 Myrtle Ave., Takoma Park, Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Passenger in car that struck bridge. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 3:58 A.M. 12-25-67 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 13 | |
| 20f. (City or town) Salisbury (County) Wicomico (State) Md. | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE Earl L. Royer, Md. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md. | | 22. DATE SIGNED December 26/1967 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 28, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mardela Memorial Cemetery | | 23d. LOCATION (City or Town) Mardela, Maryland (County) (State) | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | 25a. REC'D-BK REGISTRAR DEC 28 1967 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11/5/57

Handwritten signature or initials.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1 66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17791

CERTIFICATE OF DEATH

17795

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS 22-1 | |
| 3. NAME OF DECEASED (Type or print) Nilton First Collins Middle Collins Last | | 4. DATE OF DEATH DECEMBER 4 19 67 Month Day Year | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-27-1918 49 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) NEWARK, MD | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME ERNEST COLLINS | | 14. MOTHER'S MAIDEN NAME MARTHA BETHARDS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 231-09-4962 | |
| 17. INFORMANT MARTHA COLLINS | | Address Selfville MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO acute Exaggeration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Old Cerebral Thrombosis DUE TO (c) Right-sided Hemiplegia | | | INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Hypertension | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 11/25/67 , 19 67 , to Nov. 4 , 19 67 , that (I) (we) last saw the deceased alive on Nov. 4 , 19 67 , and that death occurred at 9:00 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE G. Herbert Semblly | | 22b. DATE SIGNED 12/6/67 | |
| 22c. PHYSICIAN'S NAME (Type) G. Herbert Semblly | | 22d. ADDRESS Salisbury Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12-8-67 | 23c. NAME OF CEMETERY OR CREMATORY Evergreen Lane | 23d. LOCATION (City or Town) (County) (State) Berlin Md |
| 24. FUNERAL DIRECTOR West Lane Home | | 25a. REC'D BY REGISTRAR DEC 11 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Jones | | | |

1951

WASHINGTON, D.C.

1951

OFFICE OF THE SECRETARY OF DEFENSE

REPORT ON THE PROGRESS OF THE

RESEARCH AND DEVELOPMENT

PROGRAM FOR THE YEAR 1951

AND THE RESULTS OF THE

RESEARCH AND DEVELOPMENT

PROGRAM FOR THE YEAR 1951

AND THE RESULTS OF THE

RESEARCH AND DEVELOPMENT

PROGRAM FOR THE YEAR 1951

AND THE RESULTS OF THE

RESEARCH AND DEVELOPMENT

PROGRAM FOR THE YEAR 1951

AND THE RESULTS OF THE

RESEARCH AND DEVELOPMENT

PROGRAM FOR THE YEAR 1951

AND THE RESULTS OF THE

RESEARCH AND DEVELOPMENT

OFFICE OF THE SECRETARY OF DEFENSE
WASHINGTON, D.C.
1951

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN lb Salisbury | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Vaughn Middle Conway Last Conway | | 4. DATE OF DEATH 12-8-67 Month 12 Day 8 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-16-1919 |
| 9. AGE (In years last birthday) yrs. 48 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Levin Conway | | 14. MOTHER'S MAIDEN NAME Sarah Dashield | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.II | | 16. SOCIAL SECURITY NO. W.W.II | |
| 17. INFORMANT Sarah Conway | | Address Salisbury Md. 9011 Nokomis Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Shotgun wound of abdomen DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Sudden | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during a quarrel. | |
| 20c. TIME OF INJURY Month, Day, Year Hour, g.m. 1:30 P.M. 12-8-67 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 802 Booth St. | | 20f. (City or town) (County) (State) Salisbury Wicomico Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Earl L. Royer, M.D. | | 22. DATE SIGNED 12-10-67 | |
| EXAMINER'S NAME (Type) Earl L. Royer, M.D. | | Address (Street, city, town, or county) 409 Camden Ave. Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/13/ 67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Green Acres | | 23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico Md. | |
| 24. FUNERAL DIRECTOR Clanton F. Stewart | | 25a. REC'D BY REGISTRAR DEC 18 1967 | |
| ADDRESS West Bod. Salisbury, Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

17728

187

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

collected

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17793

17798

| | | | | | | | |
|--|------------------------------|---|---|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | | | d. STREET ADDRESS 906 Spring Ave. | | | |
| 3. NAME OF DECEASED (Type or print) Franklin John Cooper | | | | 4. DATE OF DEATH 12-3-67 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 11-2-1904 | 9. AGE (In years last birthday) 63 yrs. | 10. IF UNDER 1 YEAR Months Days | | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Delivery driver | | | 10b. KIND OF BUSINESS OR INDUSTRY Wholesale Plumbing Worcester County | | 11. BIRTHPLACE (State or foreign country) U S A | | 12. CITIZEN OF WHAT COUNTRY? U S A |
| 13. FATHER'S NAME Charles M. Cooper | | | | 14. MOTHER'S MAIDEN NAME Martha Truitt | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-10-9426 | | 17. INFORMANT Mr. Douglas Cooper Md. Son: 109 Colbourne Drive, Salisbury | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial degeneration 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of the liver DUE TO (c) Third degree burns of the right lower leg. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Years Years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Set pants leg afire while sitting in car. | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Street Salisbury Wicomico Md. | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 2 P.M. 11-29-67 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street | | 20f. (City or town) (County) (State) Salisbury Wicomico Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Earl L. Royer, M.D. | | | | 22. DATE SIGNED 12-6-67 | | | |
| EXAMINER'S NAME (Type) Earl L. Royer, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 109 Gandon Ave. Salisbury, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-6-67 | | 23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery | | 23d. LOCATION (City or Town) (County) (State) Berlin Worcester Md. | |
| 24. FUNERAL DIRECTOR Holloway and Co. Salisbury, Md. | | | | 25a. REC'D BY REGISTRAR DEC 14 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

1775

1775

UNITED STATES DEPARTMENT OF AGRICULTURE

Office of the Chief of Bureau
Washington, D. C.
February 1, 1901

Y - 1

February 1, 1901

Mr. J. H. ...

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully,

Very truly yours,

John H. ...

John H. ...

Y - 1

Very truly yours,

John H. ...

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17794

17799

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel RD 463 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Sue Middle Ellen Last Cordrey | | 4. DATE OF DEATH December 10 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 17, 1964 |
| 9. AGE (In years last birthday) 3 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Delaware | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Leon R. Cordrey | | 14. MOTHER'S MAIDEN NAME Minnie H. Cordrey, rl Laurel, Del. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Minnie H. Cordrey, rl Laurel Del | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Carcinoma 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Wilm Tumor DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12/10/67 , 19 55 to 13/10/67 19 55 , that (I) (we) last saw the deceased alive on 12/10/67 19 55 , and that death occurred at 55 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE William C. Morgan M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial k | 23b. DATE THEREOF 12/13/67 | 23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery | 23d. LOCATION (City or Town) (County) (State) Laurel Del. |
| 24. FUNERAL DIRECTOR Harold Harrison Laurel Del | | 25. REC'D BY REGISTRAR DEC 15 1967 | |
| 26. REGISTRAR'S SIGNATURE Charles Jones | | 27. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17732

DEPARTMENT OF STATE

17732

17732

17732

17732

17732

17732

17732

17732

17732

17732

17732

17732

17732

17732

17732

17732

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17795

17800

| | | | |
|---|-------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DELAWARE b. COUNTY SUSSEX | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 46-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS PURM | |
| 3. NAME OF DECEASED (Type or print) William Henry Cordrey | | 4. DATE OF DEATH December 26 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUG. 5 1927 |
| 9. AGE (In years lost birthday) 40 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLANT FOREMAN | | 10b. KIND OF BUSINESS OR INDUSTRY POULTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) DELAWARE | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME FRANK W. CORDREY | | 14. MOTHER'S MAIDEN NAME MARGARET B. CORDREY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII | | 16. SOCIAL SECURITY NO. 222-20-4331 | |
| 17. INFORMANT AUBREY CORDREY | | Address MILLSBORO | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Intracerebral Hemorrhage. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Hypertension. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-23 , 19 67 , to 12-26 , 19 67 , that (I) (we) last saw the deceased alive on 12-26-67 19 67 , and that death occurred at 8:30 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Joseph C. Fitzgerald | | 22b. DATE SIGNED 12-26-67 | |
| 22c. PHYSICIAN'S NAME (Type) Joseph C. Fitzgerald | | 22d. ADDRESS Medical Center, Salisbury Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 12-28-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY MILLSBORO CEMETERY | | 23d. LOCATION (City or Town) (County) (State) MILLSBORO SUSSEX DEL. | |
| 24. FUNERAL DIRECTOR A. Douglas Nelson, Frankford | | 25a. REC'D BY REGISTRAR JAN 3 1968 | |
| 25b. REGISTRAR'S SIGNATURE Frankford | | | |

6855

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17796

CERTIFICATE OF DEATH

17801

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY in 1b 3 Yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City 23.2 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Hill Private Sanitarium Inc. | | | | d. STREET ADDRESS Old Golf Course Rd., | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First PRISCILLA Middle UPSHUR Last COVINGTON | | | | 4. DATE OF DEATH Month 12 Day 11 Year 1967 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 5, 1874 | |
| 9. AGE (In years last birthday) 93 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (County & State, or foreign country) Worcester, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME George M. Upshur | | | |
| 14. MOTHER'S MAIDEN NAME Emma Franklin | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. None | | | | 17. INFORMANT Address Mrs. Emily Whaley, Ocean City, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH even |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11 , 19 67 to 12-11 , 19 67 that (I) (we) last saw the deceased alive on 12-11 , 19 67 , and that death occurred at 6P M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Wilber R. Ellis, Jr. | | | | 22b. DATE SIGNED 12-12-67 | | 22c. PHYSICIAN'S NAME (Type) Wilber R. Ellis, Jr., M.D. | |
| 22d. ADDRESS Medical Center, Salisbury, Md. | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | |
| 23b. DATE THEREOF 12-14-1967 | | 23c. NAME OF CEMETERY OR CREMATORY All Hallow's Epis. Cem. | | 23d. LOCATION (City or Town) (County) (State) Snow Hill, Maryland | | | |
| 24. FUNERAL DIRECTOR Dennis Funeral Home | | | | 25a. REC'D BY REGISTRAR DEC 15 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17797

Item #11 info. taken from prev. birth cert.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17802

| | | | |
|--|------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manokin | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS Route # 1 Box 45 | |
| 3. NAME OF DECEASED (Type or print) First Felissa Middle Louella Last Curtis | | 4. DATE OF DEATH Month 12 Day 6 Year 67 | |
| 5. SEX F | 6. COLOR OR RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-17-67 |
| 9. AGE (In years last birthday) yrs. 2 Months 19 Days 19 Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Salisbury, Wic. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 525X IMMEDIATE CAUSE (a) Interstitial pneumonitis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SUDDEN DEATH IN INFANCY | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Earl L. Royer, M.D. | | 22. DATE SIGNED 12-7-67 | |
| EXAMINER'S NAME (Type) Earl L. Royer, M.D. | | Address (Street, city, town, or county) 409 Camden Ave. Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR William James Funeral Home Princess Anne | | 25a. REC'D BY REGISTRAR DEC 11 1967 | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

7-239731

1977

RECEIVED
JAN 10 1977
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20535
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]

[Handwritten signature]

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>1 Month</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury Tyaskin</u> d. STREET ADDRESS <u>Box 1 Tyaskin, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Milton Boyd Delcher</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 4. DATE OF DEATH <u>December 4</u> 19 <u>67</u> Month Day Year 9. AGE (In years lost birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Treasurer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Distillery</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William J. Delcher</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWI</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Boyd</u> 16. SOCIAL SECURITY NO. <u>165-07-6738</u> 17. INFORMANT Address <u>Mrs. Hazel S. Delcher P.O. Box 1 Tyaskin, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complete coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>4 yrs</u> <u>4 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tracheo bronchitis, diverticulitis</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from <u>Nov 2, 1967</u>, to <u>Dec 4, 1967</u>, that (1) (we) last saw the deceased alive on <u>Dec 4</u> 19<u>67</u>, and that death occurred at <u>2:55 PM</u>, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE <u>John S. Bulkeley</u> M.D. 22c. PHYSICIAN'S NAME (Type) | | 22b. DATE SIGNED <u>12-5-67</u> 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12/8/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson 1050 York Rd. 21204</u> | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17788

STATE OF TEXAS

1880

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "County of" and "State of" are faintly visible.]

RECEIVED AT THE CLERK'S OFFICE OF THE DISTRICT COURT OF THE COUNTY OF DALLAS, TEXAS, THIS 17TH DAY OF OCTOBER, 1880, FOR RECORD.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

177799

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN lb Snow Hill | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS 307 East Market Street | |
| 3. NAME OF DECEASED (Type or print) Elizabeth J Donaldson | | 4. DATE OF DEATH 12-23-67 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-17-1900 |
| 9. AGE (In years last birthday) 67 yrs. | | 10. BIRTHPLACE (State or foreign country) Berlin, Md. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Willia m F. Jarman | | 14. MOTHER'S MAIDEN NAME Mary Gough | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-34-9189 | |
| 17. INFORMANT Mrs. Jeanne Townsend, Snow Hill, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest DUE TO (b) 8164 DUE TO (c) Sudden | | INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car involved in a collision. | |
| 20c. TIME OF INJURY Month, Day, Year 8 P.M. 12-23-67 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Snow Hill Rd. | | 20f. (City or town) (County) (State) Snow Hill Worcester Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Earl L. Royer, M.D. | | 22. DATE SIGNED 12-26-67 | |
| EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (State) Burial | | 23b. DATE THEREOF 12-26-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY All Hallows Cemetery | | 23d. LOCATION (City or Town) (County) (State) Snow Hill Worcester Md. | |
| 24. FUNERAL DIRECTOR Dennis Funera l Home, Snow Hill, Md. | | 25a. REC'D BY REGISTRAR DEC 29 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE | |

MEDICAL CERTIFICATION

17750



17750

17750

17750

17750

17750

17750

17750

17750

17750

17750

17750

17750

17750

17750

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|------------------|-----------------------------------|--|---|--|---|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 17800 | | | | | 17805 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | | |
| a. COUNTY | | | Wicomico | | a. STATE | | | Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | Salisbury | | b. COUNTY | | | Wicomico | |
| c. LENGTH OF STAY IN 1b | | | days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | Salisbury | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? | |
| Peninsula General Hospital | | | | | Loblolly Lane | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | | | 4. DATE OF DEATH | | | | |
| First Middle Last | | | | | Month Day Year | | | | |
| RUTH MARIA DYKES | | | | | DECEMBER 13 1967 | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years 1st birthday) yrs. | |
| FEMALE | | WHITE | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 3/2/1898 | | 89 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY | |
| homemaker | | | own home | | Wicomico, Maryland | | | USA | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| James Madison Dykes | | | | | Lillie Goslee | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| no | | | none | | Miss Lena R. Dashiell, see # 2 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | 21 min | |
| IMMEDIATE CAUSE (a) Septicemia. | | | | | | | | | |
| 600.0 DUE TO | | | | | | | | | |
| (b) Chronic pyelonephritis | | | | | | | | Years - | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Uremia - ASCV. Disease. | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| Hour o.m. p.m. 19 | | | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | |
| 21. I certify that I (this hospital) attended the deceased from 12/7/1967 to 12/13/1967 that I (we) lost saw the deceased alive on 12/13/1967 and that death occurred at 11 M, from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE | | | | | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | 22d. ADDRESS | | | |
| O. J. Burton, MD | | | | | | Medical Center, Salisbury | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 12/15/1967 | | St. Johns Cemetery | | Fruitland Wico. Md. | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Franklin B. Hill, Salisbury | | | | | | DATE DEC 21 1967 | | [Signature] | |

17300

RECEIVED

1-808

Form with multiple sections and fields, including checkboxes and text areas. The form is oriented vertically and contains various labels and instructions, though the text is faint and difficult to read. The form is divided into several horizontal sections by lines. The top section contains the text 'RECEIVED' and '1-808'. The middle section contains a large, faint, handwritten-style mark that appears to be '17300'. The bottom section contains several lines of text and checkboxes. The form is oriented vertically and contains various labels and instructions, though the text is faint and difficult to read. The form is divided into several horizontal sections by lines. The top section contains the text 'RECEIVED' and '1-808'. The middle section contains a large, faint, handwritten-style mark that appears to be '17300'. The bottom section contains several lines of text and checkboxes.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17801

CERTIFICATE OF DEATH

17806

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | | c. LENGTH OF STAY IN 1b 4 wks | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | | d. STREET ADDRESS N. Division St. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) HRLEN | | | | 4. DATE OF DEATH DECEMBER 18 1967 | | | |
| 5. SEX FEMALE | | | | 6. COLOR OR RACE White | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH Apr. 24, 1889 | | | |
| 9. AGE (In years last birthday) 78 yrs. | | | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Museums | | | | 12. KIND OF BUSINESS OR INDUSTRY Own Home | | | |
| 13. BIRTHPLACE (County & State, or foreign country) Chicago, Ill. | | | | 14. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 15. FATHER'S NAME Unknown | | | | 16. MOTHER'S MAIDEN NAME Unknown | | | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO | | | | 18. SOCIAL SECURITY NO. 277-18-5707 | | | |
| 19. INFORMANT Richard J. Elwood | | | | 20. ADDRESS 501 DeWood dr. Salisbury, Maryland | | | |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma ovary metastatic 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) small bowel obstruction | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 11-28 , 19 67 to 12-18 , 19 67 , that (I) (we) last saw the deceased alive on 12-18 , 19 67 , and that death occurred at 11:15 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Robert T. Adkins | | | | 22b. DATE SIGNED 12-18-67 | | | |
| 22c. PHYSICIAN'S NAME (Type) Robert T. Adkins | | | | 22d. ADDRESS FRUITLAND, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 12/20/1967 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | | | | 23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland | | | |
| 24. FUNERAL DIRECTOR George C. Ritz | | | | 25. REC'D BY REGISTRAR DEC 26 1967 | | | |
| 26. ADDRESS Salisbury, MD | | | | 27. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13301

MINISTRY OF DEFENSE

13301

General

TO THE DIRECTOR OF THE
GENERAL STAFF
OF THE ARMY
OF THE REPUBLIC OF
ARMENIA

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17802

17807

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL PARSONSBURG</u> c. LENGTH OF STAY IN b <u>ROUTE 2</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ROUTE 2</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL PARSONSBURG</u> d. STREET ADDRESS <u>ROUTE 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>SAMUEL THEODORE ENNIS</u> First Middle Last | | | | 4. DATE OF DEATH <u>DECEMBER 7, 1967</u> Month Day Year | | | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>APRIL 21, 1886</u> 9. AGE (In years last birthday) <u>81</u> yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> | | | |
| 13. FATHER'S NAME <u>JOHN ENNIS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARTHA WHITE</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>MRS. LULA JENKINS</u> Address <u>106 FOCKS ST. SALISBURY, MD.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic heart dis.</u> DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day - 5 yrs +</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u> | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/6, 1966</u> to <u>death</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/1, 1967</u> , and that death occurred at <u>4 AM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Ernest Lamm</u> 22c. PHYSICIAN'S NAME (Type) <u>Ernest M. Lammore</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Delman, Del.</u> | | 22b. DATE SIGNED <u>12/7/67</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>12-9-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL METH. CH. CEM. WALSTON Wic. Co. Md.</u> | | 23d. LOCATION (City, town or county) (State) | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas F. Wallace</u> ADDRESS <u>Salisbury, Md.</u> | | | | 25a. REC'D BY REGISTRAR <u>DEC 8 1967</u> DATE | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1385

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b Salisbury d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wicomico Nursing Home, Booth St. Salisbury, Md. | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 411 Franklin Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Leo First PATRICK Middle FEENEY Last 5. SEX MALE 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker 10b. KIND OF BUSINESS OR INDUSTRY Produce | | | 4. DATE OF DEATH 12-5-1967 Month 12 Day 5 Year 1967 9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR: Months 5 Days 12 Hours 19 Min. 67 | | | 11. BIRTHPLACE (County & State, or foreign country) Buffalo, New York | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Patrick James Feeney | | | | | 14. MOTHER'S MAIDEN NAME Emma Garin | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. 214-10-6475 | | 17. MARITAL STATUS Informant Cassie Ellen Feeney (wife) #2 above Address Douglas & Charles Feeney (sons) | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma DUE TO (b) carcinoma of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 mos. 1 yr. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/7 , 19 67 , to 12/5 , 19 67 , that (I) (we) last saw the deceased alive on 12/4 , 19 67 , and that death occurred at 8:05 PM , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Dr. E.M. Beardsley | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12/6/67 | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. E.M. Beardsley | | | | | 22d. ADDRESS 207 Maryland Ave., Salisbury, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF Dec. 8, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | | 23d. LOCATION (City, town or county) (State) Salisbury, Maryland | | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | | | | 25a. REC'D BY REGISTRAR DEC 8 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

17803

OFFICE OF THE ATTORNEY GENERAL

17803

RECEIVED

DECEMBER 11, 1957

NEW YORK

RECEIVED

DECEMBER 11, 1957

NEW YORK

PRODUCE

TRUCKER

PATRICK JAMES FANNY

JOHN GARDIN

W. CLAUDE ELLEN FANNY (WIFE) above
DOUGLAS & CLAUDE FANNY (SONS)

214-10-612

Yes

Dr. E.M. Beardsley

203 Maryland Avenue Baltimore

Dec. 11, 1957 Patrons General

214-10-612

203 Maryland Avenue Baltimore

DEC 11 1957

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS Route # 2 Box 321B | |
| 3. NAME OF DECEASED (Type or print) Willie Lee Fletcher Jr. | | 4. DATE OF DEATH Month 12 Day 5 Year 67 | |
| 5. SEX M | 6. COLOR OR RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-2-58 |
| 9. AGE (In years last birthday) 9 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Willie Lee Fletcher Sr. | | 14. MOTHER'S MAIDEN NAME Lorene Wise | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Lorene Fletcher | | Address Pocomoke, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8124 IMMEDIATE CAUSE (a) Fracture dislocation of cervical spine DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sudden DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Child walking away from schoolbus and struck by Worcester car. Ht. 13 & Beaver Dam Rd, Pocomoke Md. | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child walking away from schoolbus and struck by Worcester car. | |
| 20c. TIME OF INJURY Month, Day, Year 5:30 P.M. 12-5-67 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ht. 13 & Beaver Dam Rd, Pocomoke Md. | | 20f. (City or town) Worcester (State) Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Earl L. Royer, M.D. | | 22. DATE SIGNED 12-6-67 | |
| EXAMINER'S NAME (Type) Earl L. Royer, M.D. | | Address (Street, city, town, or county) #09 Camden Ave. Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-10-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Halls Hill Cem. | | 23d. LOCATION (City or Town) (County) (State) Pocomoke Wcr. Md. | |
| 24. FUNERAL DIRECTOR Sam Savage Funeral Home New Church, Va. | | 25a. REC'D BY REGISTRAR DEC 11 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

12808

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b Deal Island | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS Main Road | |
| 3. NAME OF DECEASED (Type or print) Christopher Mark Ford | | 4. DATE OF DEATH Month 12 Day 19 Year 1967 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 18, 1961 |
| 9. AGE (In years last birthday) yrs. 6 | | 10. IF UNDER 1 YEAR Months 12 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child | | 10b. KIND OF BUSINESS OR INDUSTRY Student | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas Ford | | 14. MOTHER'S MAIDEN NAME Suzie Webster | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT Thomas Ford Deal Island, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 8124 | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by car. | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:30 P.M. 12-19-67 | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | 20f. (City or town) (County) (State) Dames Quarter Md. Somerset |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Earl L. Royer, M.D. | | 22. DATE SIGNED 12-21-67 | |
| EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/22/67 | 23c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery | 23d. LOCATION (City or Town) (County) (State) Winona Somerset Md. |
| 24. FUNERAL DIRECTOR Leroy Webster | | 25a. REC'D BY REGISTRAR DEC 27 1967 | |
| Address Princess Anne, Md. | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

12002

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17806

17811

| | | | | | | | |
|---|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE md b. COUNTY Somerset | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | | c. LENGTH OF STAY IN 1b Princess Anne | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Miriam Middle Rosell Last GREEN | | | | 4. DATE OF DEATH Month DECEMBER Day 30 Year 1967 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 29, 1893 | 9. AGE (In years last birthday) 74 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Princess Anne Md. U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME James H. Rosell | | | 14. MOTHER'S MAIDEN NAME Cornelia Amy Miles | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Howard M. Green Pr. Anne Md | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. Disease. DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs. Not Known. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/29/1967 to 12/30/1967 that (I) (we) last saw the deceased alive on 12/30/1967 and that death occurred at 7:45 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE [Signature] | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) [Signature] | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 1/1/68 | 23c. NAME OF CEMETERY OR CREMATORY Manakin Pres. Am | | 23d. LOCATION (City or Town) (County) (State) Princess Anne Md | | |
| 24. FUNERAL DIRECTOR Levin R. Walters | | | | 25a. REC'D BY REGISTRAR DATE JAN 2 1968 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

00851

1992

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17807

CERTIFICATE OF DEATH

17812

| | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> d. STREET ADDRESS <u>Pacific Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>EDWARD</u> First <u>RUSSELL</u> Middle <u>GREENE JR</u> Last 4. DATE OF DEATH <u>DECEMBER 21</u> 19 <u>67</u> Month Day Year | | | | | | | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>MAY 22, 1921</u> | | 9. AGE (In years last birthday) <u>46</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROCCER</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>SOMERSET, MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>E.R. GREENE SR.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>NELLIE BOUNDS</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>YES</u> <u>WW II</u> | | | 16. SOCIAL SECURITY NO. <u>219-07-7210</u> | | 17. INFORMANT Address <u>MRS. E.R. GREENE, JR</u> <u>SEE #2</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONITIS</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMATOSES</u> DUE TO (c) <u>CARCINOMA STOMACH</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>6 MOS</u> <u>1 YR-APP</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/21</u> , 19 <u>67</u> to <u>12/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/21</u> , 19 <u>67</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>John M. Bloxom</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXOM</u> | | | | | | 22b. DATE SIGNED 22d. ADDRESS <u>MEDICAL CEN., SALISBURY, MD</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 23b. DATE THEREOF <u>12/23/1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Salisbury, MD</u> | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>George H. H. - Salisbury, MD.</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>DEC 27 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

COST

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17808

CERTIFICATE OF DEATH

17813

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | c. LENGTH OF STAY IN 1b D.O.A. | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 22.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | | | d. STREET ADDRESS Mt. Herman Rd., | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First DEAN Middle PERDUE Last GUNBY | | | | 4. DATE OF DEATH Month 12 Day 14 Year 19 67 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 15, 1911 | |
| 9. AGE (In years last birthday) yrs. 56 | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction | | | 10b. KIND OF BUSINESS OR INDUSTRY Roads | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME S. Somers Gunby | | | | 14. MOTHER'S MAIDEN NAME Lizzie Perdue | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 213-12-5382 | | 17. INFORMANT Address Mrs. Dean P. Gunby. See Sec 2 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Myocardial Infarct DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-14 , 19 67 to 12-14 , 19 67 , that (I) (we) last saw the deceased alive on 12-14 , 19 67 , and that death occurred at 12-14 , 19 67 , from causes (and on the date stated above). | | | | | | | |
| 22a. SIGNATURE Wilber R. Ellis, Jr. M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12-18-67 | |
| 22c. PHYSICIAN'S NAME (Type) Wilber R. Ellis, Jr. M.D. | | | | 22d. ADDRESS Medical Center, Salisbury, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-17-1967 | | 23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | | 23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland | |
| 24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland | | | | 25a. REC'D BY REGISTRAR DATE DEC 21 1967 | | 25b. REGISTRAR'S SIGNATURE Orlando Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4085T

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>4 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>522 Lelane</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury MD 22-1</u> d. STREET ADDRESS <u>522 Lelane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Sarah E. Sunther</u> First Middle Last | | 4. DATE OF DEATH <u>Dec 25 19 67</u> Month Day Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-20-1893</u> Yrs. Months Days Min. |
| 9. AGE (In years last birthday) <u>74</u> Yrs. Months Days Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico Co</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>James Hutton</u> | | 14. MOTHER'S MAIDEN NAME <u>unk</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>unk</u> | |
| 17. INFORMANT <u>Anna Bayard</u> Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Atherosclerotic Heart Disease</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u>Indefinite</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1 Dec 1966</u> to <u>25 Dec 1967</u> that (I) (we) last saw the deceased alive on <u>25 Dec 1966</u> and that death occurred at <u>home</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Purnell</u> M.D. | | 22b. DATE SIGNED <u>29 Dec 67</u> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) <u>E. A. Purnell, M.D.</u> | | 22d. ADDRESS <u>652 W Main St, Salisbury Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <u>12/31/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u> | 23d. LOCATION (City or Town) (County) (State) <u>Salisbury Wicomico Md</u> |
| 24. FUNERAL DIRECTOR <u>West Funeral Home</u> ADDRESS <u>Baltimore</u> | | 25. REC'D BY REGISTRAR <u>Wep</u> DATE <u>JAN - 4 1968</u> | |
| | | 26. REGISTRAR'S SIGNATURE <u>Johns</u> | |

13809

RECEIVED

1881

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 17810 | | | | | | | | | |
| 17816 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | c. LENGTH OF STAY in lb <u>40 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u> | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Pearl E. Harris</u> | | | | | 4. DATE OF DEATH Month Day Year <u>December 30 1967</u> | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-20-1879</u> | | 9. AGE (In years last birthday) <u>88</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Snow Hill, Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>William Franklin P. Bailey</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary A. Dryden</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>220 466625</u> | | 17. INFORMANT Address <u>Herbert B. Harris, Snow Hill, Md.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Rt. Hip, status post-op nailing</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>Years</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11-20</u> , 19 <u>67</u> , to <u>12-30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-30</u> , 19 <u>67</u> , and that death occurred at <u>6:50 PM</u> , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Charles H. Winnacott</u> | | | | | 22b. DATE SIGNED <u>12-30-67</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Charles H. Winnacott</u> | | |
| 22d. ADDRESS <u>Deer's Head State Hospital</u> | | | | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Jan. 2, 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Spence Baptist</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Snow Hill, Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Norman F. Harris, Snow Hill, Md.</u> | | | | | 25a. REC'D BY REGISTRAR DATE <u>JAN 2 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

17818

TECHNICAL OF INDIAN

17818

Technical of Indian

17818

Technical of Indian

17818

Technical of Indian

Technical of Indian

Technical of Indian

Technical of Indian

Technical of Indian

Technical of Indian

Technical of Indian

Technical of Indian

Technical of Indian

Technical of Indian

Technical of Indian

Technical of Indian

Technical of Indian

Technical of Indian

Technical of Indian

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebron</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u> | | d. STREET ADDRESS <u>Rt #1 Box 85</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>C</u> Last <u>HAYWARD</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1967</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>NEGRO</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-17-1890</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 9b. AGE (In years last birthday) <u>77</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Snow Hill</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Sid. Custis</u> | | 14. MOTHER'S MAIDEN NAME <u>Lizzie Deal (Unknown)</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Virginia Norman Rt #1 Box 85</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Recurring Cerebral Thrombosis</u> DUE TO (c) <u>Hypertensive C.V. Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>20 days</u> <u>Several yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes, Hypertension</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug 25</u> , 19 <u>67</u> to <u>Dec. 29</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Dec. 28</u> , 19 <u>67</u> , and that death occurred at <u>10:15</u> AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Herbert Semblly</u> M.D. | | 22b. DATE SIGNED <u>12/29/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Herbert Semblly</u> | | 22d. ADDRESS <u>Salisbury, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>1-3-68</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u> | 23d. LOCATION (City or Town) (County) (State) <u>Salisbury Wico. Md</u> |
| 24. FUNERAL DIRECTOR <u>Loretta B. Jolley</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| ADDRESS <u>Jersey Rd. Rt #2 Salisbury, Md</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

12801

INSTITUTE OF CLAIR

12801

12801

12801

12801

12801

12801

12801

12801

12801

12801

12801

12801

12801

12801

12801

12801

12801

12801

12801

12801

12801

12801

12801

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS R.D. | |
| 3. NAME OF DECEASED (Type or print) First MARTHA Middle MARY Last HEARNE | | 4. DATE OF DEATH Month DECEMBER Day 4 Year 1967 | |
| 5. SEX FEMALE | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 7, 1891 |
| 9. AGE (In years last birthday) yrs. 76 | | 10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Willards, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Staten LaCurts | | 14. MOTHER'S MAIDEN NAME Elizabeth Davis | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-32-3193 | |
| 17. INFORMANT Mr. Orville LaCurts (nephew) Pocomoke City, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 3629 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10-26, 1967 , to 12-4, 1967 , that (I) (we) lost the deceased alive on 12-4, 1967 , and that death occurred at 8:00 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Wilbur R. Ellis | | 22b. DATE SIGNED 12-4-67 | |
| 22c. PHYSICIAN'S NAME (Type) Wilbur R. Ellis | | 22d. ADDRESS Medical Center, Salisbury, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 7, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Willards Cemetery | | 23d. LOCATION (City or Town) (County) (State) Willards, Maryland | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | 25a. REC'D BY REGISTRAR DATE DEC 7 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

1981

RECORD OF DEATH

1981

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DELAWARE b. COUNTY SUSSEX ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN lb 46.3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS FRANKFORD | |
| 3. NAME OF DECEASED (Type or print) First Middle Last OCLA A. Hudson | | 4. DATE OF DEATH Month Day Year December 2 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-9-1884 |
| 9. AGE (In years last birthday) 83 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE (RET.) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME SELBY LEWIS | | 14. MOTHER'S MAIDEN NAME IRENE E. LEWIS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 222-24-322 | |
| 17. INFORMANT LESTER HUDSON, FRANKFORD | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASGV.D DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Panatitis, Ca of Pancreas suspected | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10-27 , 19 67 , to 12-2 , 19 67 , that (I) (we) last saw the deceased alive on 12-2-67 , 19 67 , and that death occurred at 11:40 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Joseph C. Fitzgerald | | 22b. DATE SIGNED 12-2-67 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 12-6-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY CAREY'S METH. Cem. | | 23d. LOCATION (City or Town) (County) (State) FRANKFORD SUSSEX, DE. | |
| 24. FUNERAL DIRECTOR A. Douglas Nelson, Frankford | | 25a. REC'D BY REGISTRAR DEC 20 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

81877

WTA 10-10-1940

1181

DATE

COMMENTS

Latitudes between 10 and 15

10

10

10

10

10

10

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17814

CERTIFICATE OF DEATH

17900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. LENGTH OF STAY IN lb <u>Berlin 7</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u> | | d. STREET ADDRESS <u>Berlin 7</u> | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Henry J. Johnson</u> | | 4. DATE OF DEATH <u>December 28</u> 19 <u>67</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>NEGRO</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>2-13-1900</u> |
| 9. AGE (In years lost birthday) <u>67</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Berlin</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Daniel Johnson</u> | | 14. MOTHER'S MAIDEN NAME <u>Lizzie Marshall</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Salie Johnson</u> | | Address <u>Berlin, Md</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerosis Heart Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-22, 1967</u> to <u>12-28, 1967</u> , that (II) (we) lost saw the deceased alive on <u>12-28, 1967</u> , and that death occurred at <u>8 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>William R. Eccles Jr.</u> | | 22b. DATE SIGNED <u>1-1-68</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>William R. Eccles Jr.</u> | | 22d. ADDRESS <u>Berlin, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>1-2-68</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New Bethel</u> | 23d. LOCATION (City or Town) (County) (State) <u>Berlin Wor. Md.</u> |
| 24. FUNERAL DIRECTOR <u>Louisa B. Jolly</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Louisa B. Jolly</u> | | 25c. DATE <u>JAN 12 1968</u> | |

11000

MINISTRY OF DEFENSE

11000

General Order No. 11000

11000

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17815

17820

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Girdletree</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>W.</u> Last <u>Johnson</u> | | | 4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1967</u> | | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 22, 1887</u> | 9. AGE (In years lost birthday) <u>80</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Girdletree, Maryland</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>Robert W. Johnson</u> | | | | |
| 14. MOTHER'S MAIDEN NAME <u>Jenny Trader</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | | | |
| 16. SOCIAL SECURITY NO. <u>Unknown</u> | | | 17. INFORMANT Address <u>Elsie R. Johnson, Girdletree Md.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis End</u> DUE TO (c) <u>Hypertension</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>332X</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Carcinoma of Prostate</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | 21. I certify that (I) (this hospital) attended the deceased from <u>Dec 27, 1967</u> , to <u>Dec 27, 1967</u> , that (I) (we) lost saw the deceased alive on <u>Dec 27, 1967</u> , and that death occurred at <u>5:30 P.M.</u> , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE <u>Thomas C. Hill Jr.</u> M.D. | | | 22b. DATE SIGNED <u>12-27-67</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Thomas C. Hill Jr.</u> | | |
| 22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md.</u> | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | |
| 23b. DATE THEREOF <u>Dec. 30, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Beth Eden Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Worcester Co. Maryland</u> | | | |
| 24. FUNERAL DIRECTOR <u>Norman F. Morris, Snow Hill, Md.</u> | | | 25a. REC'D BY REGISTRAR DATE <u>JAN 2 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|--|---------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b Adm. in 1d 12/9/67 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 110 W. Vine Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First (ETTA) Middle GROETTA Last ARTHUR JONES | | 4. DATE OF DEATH Month December Day 10 Year 19 67 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 5, 1888 |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work | | 10b. KIND OF BUSINESS OR INDUSTRY none | |
| 11. BIRTHPLACE (County & State, or foreign country) Hooper's Island, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Arthur Parks | | 14. MOTHER'S MAIDEN NAME Mary Dean | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-14-3058F2 | |
| 17. INFORMANT Mr. Ardie A. Jones (Son) 220 Ballard Ave., Baltimore, Md. 21220 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral thrombosis</i> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <i>degenerative heart disease - chronic heart failure</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>12/4</i> to <i>12/10</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>12-10</i> 19 <i>67</i> , and that death occurred at <i>5:10</i> M, from the causes and on the date stated above. P.M. | | | |
| 22a. SIGNATURE <i>Dr. E.M. Beardsley</i> | | 22b. DATE SIGNED December 11, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. E.M. Beardsley | | 22d. ADDRESS 207 Maryland Ave., Salisbury, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 13, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park | | 23d. LOCATION (City, town or county) (State) Salisbury, Maryland | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | 25a. REC'D BY REGISTRAR DATE DEC 13 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

13818

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17817

CERTIFICATE OF DEATH

17822

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>13 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> 232 d. STREET ADDRESS <u>TRANSNICE ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Mildred Louise Jones</u> | | | 4. DATE OF DEATH Month Day Year <u>December 24 1967</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAR. 4 1907</u> | 9. AGE (In years last birthday) <u>60</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u> | | | |
| 13. FATHER'S NAME <u>ERMON SIDAWAY</u> | | | 14. MOTHER'S MAIDEN NAME <u>ONKITA SECHRIST</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>218-16-6589</u> | | 17. INFORMANT <u>WILBUR JONES, Snow Hill MD</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | 21. I certify that (I) (this hospital) attended the deceased from <u>12/11</u> , 19 <u>67</u> to <u>12/24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> , 19 <u>67</u> , and that death occurred at <u>1:45</u> A.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>David H. Gibbons MD</u> | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. | | 22b. DATE SIGNED | | |
| 22c. PHYSICIAN'S NAME (Type) <u>DAVID H. GIBBONS MD</u> | | | 22d. ADDRESS <u>MEDICAL CENTER, SALISBURY MD.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>12/28/1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Alt. Hallow's Epis Cem.</u> | 23d. LOCATION (City or Town) (County) (State) <u>Snow Hill MD.</u> | | | | |
| 24. FUNERAL DIRECTOR <u>Donald C. Bonds</u> | | | ADDRESS <u>Snow Hill, MD</u> | | 25a. REC'D BY REGISTRAR DATE <u>DEC 29 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

19817

OFFICE OF CHIEF

19817



RECEIVED
JAN 10 1981
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
JAN 10 1981
RECEIVED
JAN 10 1981
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 221 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS Lillian Street | |
| 3. NAME OF DECEASED (Type or print) Rev. WILLIAM HESPIOR KOHL | | 4. DATE OF DEATH Month December Day 14 Year 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 25, 1897 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Minister | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Phillipsburg, N. J. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 220-32-0633A | |
| 17. INFORMANT Mrs. Gordy Kline (Daughter) | | Address Lillian St., Hebron, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 1533 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) Metastatic Carcinoma OUE TO (c) Carcinoma of Sigmoid Colon 2 INTERVAL BETWEEN ONSET AND DEATH 6 weeks 2 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from November, 1967 , to 12-14, 1967 , that (I) (we) last saw the deceased alive on 12-14 1967 , and that death occurred at 5:05 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Dr. Hunter Mann, Jr. | | 22b. DATE SIGNED Dec. 15/1967 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Hunter Mann, Jr. | | 22d. ADDRESS 209 Maryland Ave., Salisbury, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 17, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens | | 23d. LOCATION (City, town or county) (State) Salisbury, Maryland | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | 25a. REC'D BY REGISTRAR DEC 19 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

11823

17814

100-10-10000 (100000) 11111111
100-10-10000 (100000) 11111111

100-10-10000 (100000) 11111111
100-10-10000 (100000) 11111111

100-10-10000 (100000) 11111111
100-10-10000 (100000) 11111111

100-10-10000 (100000) 11111111
100-10-10000 (100000) 11111111

100-10-10000 (100000) 11111111
100-10-10000 (100000) 11111111

1
X2
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|-----------------------------------|---|---|---|-------------------------------------|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 17819 | | | | | | | | | |
| 17824 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | c. LENGTH OF STAY IN 1b Adm. in 1d 12/29/67 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | | | | d. STREET ADDRESS Rt. #6, Parker Road | | | | |
| 3. NAME OF DECEASED (Type or print) JOHN | | | First Middle Last JOHN WESLEY LAWRENCE | | 4. DATE OF DEATH December 31 19 67 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH January 1, 1906 | | 9. AGE (In years last birthday) 61 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cable Foreman | | | 10b. KIND OF BUSINESS OR INDUSTRY Telephone Company | | 11. BIRTHPLACE (County & State, or foreign country) New York City, N. Y. | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William G. Lawrence | | | | | 14. MOTHER'S MAIDEN NAME Martha Gilmore | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 212-10-0430 | | 17. INFORMANT Mrs. Charlotte J. Lawrence (Wife) Rt. #6, Parker Road, Salisbury, Maryland | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Lobar Pneumonia 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary to Pulmonary Emphysema DUE TO (c) Mild Arteriosclerosis | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days Few Yr 22222 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from Mar. 28, 19 67, to Dec. 31, 19 67 that (I) (we) last saw the deceased alive on Dec. 31, 19 67, and that death occurred at 4 P.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE G. Herbert Sembly | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED Jan. 2, 1968 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. G. Herbert Sembly | | | | | 22d. ADDRESS 400 E. Church St., Salisbury, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Jan. 4, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park | | | 23d. LOCATION (City, town or county) (State) Salisbury, Maryland | | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | | | | 25a. REC'D BY REGISTRAR JAN 4 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

RECEIVED
JAN 10 1968
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or report body.]

DATE: 1/10/68
BY: [Illegible]
[Illegible text at bottom of page, possibly a signature block or distribution list.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 17820 | | | | | | | | | |
| 17825 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | c. LENGTH OF STAY IN 1b 154 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital | | | | | d. STREET ADDRESS -- | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH WILLIAM LITTLETON | | | | | 4. DATE OF DEATH Month Day Year 12 12 1967 | | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 5, 1901 | | 9. AGE (In years lost birthday) 66 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman | | 10b. KIND OF BUSINESS OR INDUSTRY City Transit Co. | | 11. BIRTHPLACE (County & State, or foreign country) Gumboro, Delaware | | | 12. CITIZEN OF WHAT COUNTRY USA | | |
| 13. FATHER'S NAME Horace Littleton | | | | | 14. MOTHER'S MAIDEN NAME Clara Lewis | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 179-03-6820 | | 17. INFORMANT Mrs. Brenda L. Bradford (Sister) 920 Riverside Drive, Salisbury, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Acute pulmonary edema DUE TO (c) Hypertensive arteriosclerotic heart disease | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days 24 hours Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that 1 (this hospital) attended the deceased from July 11, 1967 , to December 12, 1967 , that (X) (we) last saw the deceased alive on December 12, 1967 , and that death occurred at 6:15 AM , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE C. H. Winnacott, M.D. | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 12/12/67 | | | |
| 22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M.D. | | | | 22d. ADDRESS Deer's Head State Hospital, Salisbury, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 14, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery | | 23d. LOCATION (City or Town) (County) (State) Delmar, Delaware | | | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | | | ADDRESS HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | 25a. REC'D BY REGISTRAR DATE DEC 15 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

0525

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|---|---|---|---|---|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>Adm. in ID</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: "Residence" before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>204 Linwood Ave.</u> | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>RUTH</u> <u>LUCINDA</u> | | | First <u>RUTH</u> Middle <u>LUCINDA</u> Last <u>Littleton</u> | | 4. DATE OF DEATH <u>December 29 1967</u> Month <u>December</u> Day <u>29</u> Year <u>1967</u> | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>February 23, 1898</u> <u>69</u> yrs. | | 9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>69</u> Days <u>69</u> Hours <u>69</u> Min. <u>69</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico County, Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>David H. Tingle</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Martha Parsons</u> | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>217-10-3600 B</u> | | 17. INFORMANT <u>Mr. William Z. Littleton (Husband)</u> Address <u>204 Linwood Ave., Salisbury, Maryland</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gaugrenous otitis</u> <u>260X</u> DUE TO (b) <u>diabetic acidosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>pneumonia</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>hrs</u> <u>yes</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec 28, 1967</u> to <u>Dec 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 29</u> <u>1967</u> , and that death occurred at <u>4:00</u> AM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>John T. Burkeley</u> | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>12-29-67</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>John T. Burkeley</u> | | | | | 22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md.</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Jan. 2, 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Springhill Memory Gardens</u> | | 23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u> | | | | | ADDRESS <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u> | | 25a. REC'D BY REGISTRAR <u>JAN 4 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles George</u> | | |

17321

February 23, 1950

Albany, New York

My dear Sir:

Mr. William E. Lister (Husband)
201 Lincoln Ave., Albany, N.Y.

David H. Tingle

No.

ALBANY, NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17827

| | | | |
|---|---------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS Antioch Ave. | |
| 3. NAME OF DECEASED (Type or print) First Everett Middle Hayman Last Long | | 4. DATE OF DEATH Month 12 Day 3 Year 67 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-14-12 |
| 9. AGE (In years last birthday) 55 yrs. | | 10. IF UNDER 1 YEAR Months 19 Days 2 Hours 2 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY U S A | |
| 13. FATHER'S NAME Ira Oscar Long | | 14. MOTHER'S MAIDEN NAME Jennie Hayman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Earl L. Royer, M.D. | | 22. DATE SIGNED 12-4-67 | |
| EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/5/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Beechwood Cemetery | | 23d. LOCATION (City or Town) (County) (State) Princess Anne, Md. | |
| 24. FUNERAL DIRECTOR James L. Hinman | | 25a. REC'D BY REGISTRAR DEC 7 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13032

1382

13032

13032

13032

13032

13032

13032

13032

13032

13032

13032

13032

13032

13032

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div> | | | | | | | | | |
|---|-------------------------------------|--|--|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hosp.</u> | | | | | d. STREET ADDRESS <u>Corporation Road</u> | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Paul Lundy</u> | | | | | 4. DATE OF DEATH Month Day Year <u>12-8-67</u> 19 | | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Apr. 4, 1895</u> | | 9. AGE (In years last birthday) yrs. <u>72</u> | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>contractor</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>home bldgs.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Traer, Iowa</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Henry Lundy</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Charlotte Every</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Address <u>Neal E. Lundy, Sharptown, Maryland</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u> EXAMINER'S NAME (Type) | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 22. DATE SIGNED <u>12-8-67</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>12/12/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Maple Grove Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Mason Michigan</u> | | |
| 24. FUNERAL DIRECTOR <u>Wm. Harrison Land Dela.</u> | | | | | 25a. REC'D BY REGISTRAR DATE <u>DEC 15 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

13823

13824

WILSON, JAMES H. (1891-1961)

WILSON, JAMES H.

WILSON, JAMES H.

13825

WILSON, JAMES H. (1891-1961)

WILSON, JAMES H. (1891-1961)

17824

CERTIFICATE OF DEATH

17829

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville 23-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS RFD | |
| 3. NAME OF DECEASED (Type or print) Lillie M. McCabe | | 4. DATE OF DEATH December 2 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 1, 1884 |
| 9. AGE (In years last birthday) 83 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William H. Holloway | | 14. MOTHER'S MAIDEN NAME Elizabeth Davidson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) XX | | 16. SOCIAL SECURITY NO. XX | |
| 17. INFORMANT James F. McCabe Showell | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Acute Myocardial Infarction DUE TO (c) ASCDP | | | INTERVAL BETWEEN ONSET AND DEATH 5 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) right hemiparesis, senility, obesity | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 11-27 , 19 67 , to 12-2 , 19 67 , that (I) (we) last saw the deceased alive on 12-2 , 19 67 , and that death occurred at 6:45 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Joseph C. Fitzgerald | | 22b. DATE SIGNED 12-2-67 | |
| 22c. PHYSICIAN'S NAME (Type) Joseph C. Fitzgerald | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/5/67 | 23c. NAME OF CEMETERY OR CREMATORY Odd Fellows | 23d. LOCATION (City or town) (County) (State) BISHOPVILLE MD |
| 24. FUNERAL DIRECTOR Watson & Holey, Salisbury, Del. | | 25a. REC'D BY REGISTRAR DEC 7 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PS&T 7

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (4)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS Bird Hill Road | |
| 3. NAME OF DECEASED (Type or print) Kenneth Allen Merrick | | 4. DATE OF DEATH Month 12 Day 14 Year 1967 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-9-67 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) yrs. 3 IF UNDER 1 YEAR: Months 3 Days 3 Hours 19 Min. |
| 11. BIRTHPLACE (State or foreign country) SALISBURY, MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Robert Merrick | | 14. MOTHER'S MAIDEN NAME Maxine GLEATON | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT ROBERT H. MERRICK STOCKTON, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5251 IMMEDIATE CAUSE (a) Interstitial pneumonitis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH days |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SUDDEN DEATH IN INFANCY | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Earl L. Royer, M.D. | | 22. DATE SIGNED 12-14-67 | |
| EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF DEC. 14, 1967 | 23c. NAME OF CEMETERY OR CREMATORY FIRST BAPTIST, CEM | 23d. LOCATION (City or Town) (County) (State) Pocomoke City, Worcester |
| 24. FUNERAL DIRECTOR Watson Funeral Home Pocomoke, Md. | | 25a. REC'D BY REGISTRAR DEC 18 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

7-239787

17825

17825

17825

17825

17825

17825

17825

17825

17825

17825

17825

17825

17825

17825

17825

17825

17825

17825

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|-------------------------------------|---|---|---|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u> | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | c. LENGTH OF STAY in 1b <u>4 Months</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u> | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wicomico Nursing Home, Salisbury, Md.</u> | | | | | d. STREET ADDRESS <u>22-1</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Ella Frances Messick</u> | | | | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>20</u> Year <u>1967</u> | | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8/6/1871</u> | | 9. AGE (In years last birthday) <u>96</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico, Md.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | |
| 13. FATHER'S NAME <u>George W. Messick</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Mitilda Evans</u> | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service) <u> </u> | | | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT <u>Mrs. Blanche Cox, Nanticoke, Md.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332A DUE TO (b) <u>generalized atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>yrs.</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Degenerative heart disease</u> | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/22</u> , 19 <u>67</u> , to <u>12-20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-20</u> 19 <u>67</u> , and that death occurred at <u>8:20 A.</u> from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Ed Beardsley</u> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>12/20/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Ed Beardsley</u> | | | | | | 22d. ADDRESS <u>Salisbury, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>12/23/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Turners Cem.</u> | | | 23d. LOCATION (City, town or county) (State) <u>Nanticoke, Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>E. Messick Bivare, Md.</u> | | | | | | 25a. REC'D BY REGISTRAR DATE <u>DEC 27 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

17836

2-1-1871

* 2/1/1871

George W. Mosier

M. T. 1871

Feb 1871

1871

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| <div style="display: flex; justify-content: space-between;"> 17827 MARYLAND STATE DEPARTMENT OF HEALTH 17832 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | | c. LENGTH OF STAY IN 1b <u>4 days</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal Oak</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u> | | | | d. STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>T. Miles</u> Last | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>19 67</u> | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH <u>11/6/1903</u> | | 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cover Sheet Metal Shop</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Lawrence Pa.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>George Miles</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Olive Polly</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>177-03-7229</u> | | 17. INFORMANT <u>Mrs. Russell Miles, Royal Oak, Md.</u> | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tracheo - Bronchitis, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Emphysema</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Duodenal Ulcers with bleeding - weeks</u> | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 19, 19 67</u> , to <u>Dec. 23, 19 67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 23, 19 67</u> , and that death occurred at <u>7 A.M.</u> from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>A. C. Mitchell</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>12/24/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, MD.</u> | | | | 22d. ADDRESS <u>Deer's Head State Hospital, Salisbury Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12/26/1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u> | | | | 23d. LOCATION (City or Town) (County) (State) <u>Easton, Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>MAURICE E. NEUNAM & SON, Easton, Md.</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>JAN 2 1968</u> | | | | 25b. REGISTRAR'S SIGNATURE <u>James Judgen</u> | | | |

15821

15831

CERTIFICATE OF DEATH

15831

15831

15831

CERTIFICATE OF DEATH

17833

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital | | | | d. STREET ADDRESS 311 Carey Avenue | | | |
| 3. NAME OF DECEASED (Type or print) MARY | | First ANN | | Last MOSLEY | | 4. DATE OF DEATH Month DEC. Day 9th Year 19 67 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 12/1912 | |
| 9. AGE (In years last birthday) 55 yrs. | | IF UNDER 1 YEAR Months 55 Days 55 | | IF UNDER 24 HRS. Hours 55 Min. 55 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-Laborer-Shirt Factory | | | | 10b. KIND OF BUSINESS OR INDUSTRY Accomac Co., Virginia | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Jacob Campbell | | | | 14. MOTHER'S MAIDEN NAME Annie Emily Young | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 214-10-7629 | | | |
| 17. INFORMANT Mr. Charles E. Mosley (Husband) - Item #2 above Mr. Wm. C. Mosley (Son) R. D. #7 Salisbury, Md. Glen Ave. Ext. 21801 | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral aneurysm rupture DUE TO (b) arteriosclerosis DUE TO (c) hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A | | | |
| 20c. TIME OF INJURY Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1967 to 1967 , that (I) (we) last saw the deceased alive on Dec. 11/1967 , and that death occurred at App: 5:45 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Dr. Carrie I. Hearn M.D. | | | | 22b. DATE SIGNED Dec. 11/1967 | | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Carrie I. Hearn | | | | 22d. ADDRESS N. Division St. Salisbury, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 11/1967 | | 23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park | | 23d. LOCATION (City, town or county) (State) Salisbury, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY | | | | 25a. REC'D BY REGISTRAR DEC 13 1967 | | | |
| ADDRESS SALISBURY, MARYLAND | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ASST

2011年10月

STERN

(continued from page 6)

1. 2007-2008

1000

[illegible]

• • • • •

Carrie I. Harris

Division of Statistics, Bureau of Census

4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|---|---|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | c. LENGTH OF STAY IN lb 16 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital | | | | | d. STREET ADDRESS 421 Robbins Street | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CECIL JONES MURPHY First Middle Last | | | | | 4. DATE OF DEATH 12 27 19 67 Month Day Year | | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH April 7, 1892 | | 9. AGE (In years last birthday) 75 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Frank H. Jones | | | | | 14. MOTHER'S MAIDEN NAME Annie Insley | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Mr. O'Neill Murphy, Cambridge, Maryland Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous CVA - 10/23/67 | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (s) (this hospital) attended the deceased from December 11, 19 67 to December 27, 19 67 , that (h) (we) last saw the deceased alive on December 27, 19 67 , and that death occurred at 6:05 PM , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE A. C. Mitchell, M.D. | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22b. DATE SIGNED 12/28/67 | |
| 22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D. | | | | | 22d. ADDRESS Deer's Head State Hospital, Salisbury, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 31 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park | | | 23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland | | |
| 24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland ADDRESS | | | | | 25a. REC'D BY REGISTRAR JAN 3 1968 DATE | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | | |

14034

UNITED STATES OF AMERICA

14034

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17830

CERTIFICATE OF DEATH

17835

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 22-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS 421 Oak Street | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ERMAE MAE PARKER | | 4. DATE OF DEATH Month Day Year DECEMBER 5 19 67 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 8, 1899 |
| 9. AGE (In years last birthday) 68 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY none | |
| 11. BIRTHPLACE (County & State, or foreign country) Pittsville, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Clem Elliott | | 14. MOTHER'S MAIDEN NAME Charlotte Holloway | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-34-8859 | |
| 17. INFORMANT Mrs. Clara Bell (Daughter) | | Address 421 Oak Street, Salisbury, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 5 hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic mellitus - generalized arteriosclerosis | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from June , 19 67 , to 12/5 , 19 67 , that (I) (we) last saw the deceased alive on 12/5 , 19 67 , and that death occurred at 8:30 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Earl Beardsley | | 22b. DATE SIGNED December 5, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) EARL Beardsley | | 22d. ADDRESS MARYLAND AVE. Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec. 7, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park | 23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | 25a. REC'D BY REGISTRAR DEC 8 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

1-1833

RECEIVED

1-1833

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18-21 Film 396
1-8-68 ams
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 22-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 713 Dennis Street | | d. STREET ADDRESS 713 Dennis Street | |
| 3. NAME OF DECEASED (Type or print) First Lillian Middle Parker Last Parker | | 4. DATE OF DEATH Month 12 Day 19 Year 67 | |
| 5. SEX F | 6. COLOR OR RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 6/17/1921 |
| 9. AGE (In years last birthday) yrs. 46 | | IF UNDER 1 YEAR Months 12 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY Virginia | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Benjamin Richards | | 14. MOTHER'S MAIDEN NAME Leolis Richards | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. Leolis Richards Hampton, Va. | |
| 17. INFORMANT Leolis Richards Hampton, Va. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure to cold 932.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic alcoholism | | INTERVAL BETWEEN ONSET AND DEATH days | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Alcoholic at home alone with no heat. | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 12-19 p.m. 1967 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Own home | | 20f. (City or town) (County) (State) Salisbury Wicomico Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Earl L. Royer, M.D. | | 22. DATE SIGNED 12-21-67 | |
| EXAMINER'S NAME (Type) Earl L. Royer, M.D. | | Address (Street, city, town, or county) 109 Camden Ave. Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/31/67 | |
| 23c. NAME OF CEMETERY OR CREMATOR Hall Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Pocomoke Worcester Md. | |
| 24. FUNERAL DIRECTOR Clinton F. Stewart | | 25a. REC'D BY REGISTRAR DEC 28 1967 | |
| ADDRESS Salisbury Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

1783

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

1

1783

Michigan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---------------------------------------|--|---|---|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 17832 | | | | | | | | | | |
| 17837 | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | c. LENGTH OF STAY IN lb <u>29 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u> | | | | | d. STREET ADDRESS <u>422 Stewart Place</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>PARSONS</u> Last <u>PARSONS</u> | | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>19 67</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>C</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5/5/1912</u> | | 9. AGE (In years last birthday) <u>55</u> yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>James Parsons</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Fannie Wright</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Address</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>150x</u> IMMEDIATE CAUSE (a) <u>Primary carcinoma of the esophagus with metastasis to regional lymphnodes</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u> | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that <u>(I)</u> (this hospital) attended the deceased from <u>November 11, 19 67</u> to <u>December 13 19 67</u> , that (I) (we) last saw the deceased alive on <u>December 13 19 67</u> , and that death occurred at <u>6:35 P.M.</u> from causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE <u>C. H. Winnacott</u> | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>12/11/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>C. H. Winnacott, M.D.</u> | | | | | 22d. ADDRESS <u>Deer's Head State Hospital, Salisbury,</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12/17/ 67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u> | | | 23d. LOCATION (City or Town) (County) (State) <u>Salisbury Wicomico Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Clinton F. Stewart</u> | | | | | ADDRESS <u>Salisbury Md.</u> | | 25a. REC'D BY REGISTRAR DATE <u>DEC 20 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u> | |

14338

CERTIFICATE OF DEATH

DATE

TIME

PLACE

AGE

SEX

CAUSE

DATE

TIME

PLACE

AGE

SEX

CAUSE

DATE

CAUSE OF DEATH

CAUSE OF DEATH

DATE

CAUSE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury <i>22-1</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital | | d. STREET ADDRESS 704 Goldsboro Street 705 Howard Street | |
| 3. NAME OF DECEASED (Type or print) First BERTIE Middle MAE Last PRYOR | | 4. DATE OF DEATH Month 12 Day 27 Year 1967 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 7, 1885 |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Crisfield, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Isaac Byrd | | 14. MOTHER'S MAIDEN NAME Marion Stevenson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. -- | |
| 17. INFORMANT Mr. Charles E. Pryor (Husband) 704 Goldsboro, St., Salisbury, Maryland | | 17. ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subtotal coronary occlusion DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Old cerebral thrombosis | | INTERVAL BETWEEN ONSET AND DEATH -- Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old cerebral thrombosis | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 9, 1957 , to December 27, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 27, 1967 , and that death occurred at 5:20PM , from causes and on the date stated above. | | 22b. DATE SIGNED 12/28/67 | |
| 22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. | | 22d. ADDRESS Deer's Head State Hospital, Salisbury | |
| 22a. SIGNATURE <i>L. V. Maldve</i> | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec. 30, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens | 23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | 25a. REC'D BY REGISTRAR JAN 2 1968 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

17533

17533

CERTIFICATE OF EVIDENCE

DEPARTMENT OF AGRICULTURE, BUREAU OF PLANT INDUSTRY, WASHINGTON, D. C.

THIS CERTIFICATE IS ISSUED TO THE FOLLOWING PARTY FOR THE PURPOSE OF IDENTIFYING THE FOLLOWING SPECIMEN(S) AS BEING THE PROPERTY OF THE FOLLOWING PARTY:

NAME OF PARTY: _____

ADDRESS OF PARTY: _____

CITY AND STATE: _____

COUNTRY: _____

DATE OF RECEIPT: _____

BY: _____

FOR THE PURPOSE OF IDENTIFYING THE FOLLOWING SPECIMEN(S) AS BEING THE PROPERTY OF THE FOLLOWING PARTY:

NAME OF PARTY: _____

ADDRESS OF PARTY: _____

CITY AND STATE: _____

COUNTRY: _____

DATE OF RECEIPT: _____

BY: _____

FOR THE PURPOSE OF IDENTIFYING THE FOLLOWING SPECIMEN(S) AS BEING THE PROPERTY OF THE FOLLOWING PARTY:

NAME OF PARTY: _____

ADDRESS OF PARTY: _____

CITY AND STATE: _____

COUNTRY: _____

DATE OF RECEIPT: _____

BY: _____

FOR THE PURPOSE OF IDENTIFYING THE FOLLOWING SPECIMEN(S) AS BEING THE PROPERTY OF THE FOLLOWING PARTY:

NAME OF PARTY: _____

ADDRESS OF PARTY: _____

CITY AND STATE: _____

COUNTRY: _____

DATE OF RECEIPT: _____

BY: _____

FOR THE PURPOSE OF IDENTIFYING THE FOLLOWING SPECIMEN(S) AS BEING THE PROPERTY OF THE FOLLOWING PARTY:

NAME OF PARTY: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital | | d. STREET ADDRESS R.D.#3 | |
| 3. NAME OF DECEASED (Type or print) First George Middle B. Last Robbins | | 4. DATE OF DEATH Month December Day 29 Year 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Sept. ?, 1885 |
| 9. AGE (In years lost birthday) 82 yrs. | | 10. IF UNDER 1 YEAR Months 09 Days 2 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman | | 10b. KIND OF BUSINESS OR INDUSTRY Seafood | |
| 11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George Robbins | | 14. MOTHER'S MAIDEN NAME Louise Bell | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. unk | |
| 17. INFORMANT Hospital Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis - R. T. Hemiplegia | | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12/7/67 , 19 67 , to 12/29/67 , 19 67 , that (I) (we) last saw the deceased alive on 12/29/67 , 19 67 , and that death occurred at 11P. M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Charles H. Winnacott | | 22b. DATE SIGNED 12/30/67 | |
| 22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott, M.D. | | 22d. ADDRESS Box 2018, Salisbury, Md. - 21801 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Jan 1, 1968 | 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery | 23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland |
| 24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland | | 25a. REC'D BY REGISTRAR DAIAN 4 1968 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

MEDICAL CERTIFICATION

13884

CERTIFICATE OF DEATH

13884

2

1

1

1

1

1

13884

13884

13884

13884

13884

13884

13884

13884

13884

13884

13884

13884

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 17835 | | | | | | | | | | 17840 | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--------------------------------|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | |
| Delcie | | | | | Mae | | | | | Roberts | | | | | December 17 1967 | | | | | 10 p M | | | | | | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | | | | | |
| female | | | | | colored | | | | | Jan. 2, 1897 | | | | | 70 YRS. | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | Md. | | | | | | | | | | | | | | |
| Maryland | | | | | U.S.A. | | | | | | | | | | Wicomico | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| Salisbury | | | | | Pine Bluff State Hosp. | | | | | Domestic | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | |
| Maryland | | | | | Worcester | | | | | Pocomoke | | | | | | | | | | 504 Young Street | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | |
| John | | | | | - Roberts | | | | | Lizzie | | | | | - Broughton | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | Records of: | | | | | Address | | | | | | | | | | | | | | |
| no | | | | | - | | | | | 224-18-2698 | | | | | Pine Bluff State Hospital | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) chronic nephritis | | | | | | | | | | | | | | | unknown | | | | | | | | | | | | | | | | | | | |
| 592X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Oct. 24, 1967, to Dec. 17, 1967, that (X) (we) last saw the deceased alive on Dec. 17, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | DEGREE | | | | | ATTENDING PHYS. | | | | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED Dec. 18, 1967 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | | | | E. P. Ritchings, M.D., Supt. Pine Bluff State Hospital | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | 12-24-67 | | | | | Wardtown Cem. | | | | | Pocomoke Wbr. Md. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | |
| Samuel Sarge | | | | | New Church, Va. | | | | | DATE DEC 22 1967 | | | | | Charles Judge | | | | | | | | | | | | | | | | | | | |

C

I

P

D

C

I

P

D

C

I

P

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
20 M 1/64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17836

CERTIFICATE OF DEATH

17841

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 22-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First VERNON Middle GRAY Last Robertson | | 4. DATE OF DEATH Month December Day 8 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 14, 1894 |
| 9. AGE (In years last birthday) 73 yrs. | | 10. IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer & Manager | | 10b. KIND OF BUSINESS OR INDUSTRY Auto Store | |
| 11. BIRTHPLACE (County & State, or foreign country) Bivalve, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charlie Francis Robertson | | 14. MOTHER'S MAIDEN NAME Emma J. Downing | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-14-3657 | |
| 17. INFORMANT Charles V. Robertson (Son) Address Route 3, Delmar, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thromboses 3327 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH 6 weeks | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10-23, 1967 to 12-8, 1967 , that (I/we) last saw the deceased alive on 12-8, 1967 , and that death occurred at 6:00 M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE W. R. Ellis, Jr. | | 22b. DATE SIGNED 12-8-67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis, Jr. | | 22d. ADDRESS Salisbury, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 10, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Grace Episcopal Church Cemetery, Mt. Vernon, Maryland | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | 25a. REC'D BY REGISTRAR DEC 13 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

11838

11838

11838

11838

11838

11838

11838

11838

11838

11838

11838

11838

11838

11838

11838

11838

11838

11838

11838

11838

11838

11838

11838

11838

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b Adm. in 1d 11/27/67 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 135 Truitt Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) DAISEY MAE ROSS First Middle Last 4. DATE OF DEATH December 27 19 67 Month Day Year | | 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH May 8, 1898 9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former Machine Operator 10b. KIND OF BUSINESS OR INDUSTRY Shirt Factory 11. BIRTHPLACE (County & State, or foreign country) Bridgeville, Delaware 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Isaac J. Lecates 14. MOTHER'S MAIDEN NAME Mary Davis | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 214-10-8068 17. INFORMATION Mr. Vernon H. Ross (Husband) Address 135 Truitt St., Salisbury, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma totis 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma uteris DUE TO (c) Intestinal obstruction | | INTERVAL BETWEEN ONSET AND DEATH 2mo 6mo. 10d. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 5:25 PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE [Signature] 22c. PHYSICIAN'S NAME (Type) Dr. E. Kent Carney | | 22b. DATE SIGNED Dec. 28 / 1967 M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Medical Center, Salisbury, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 30, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | | 23d. LOCATION (City, town or county) (State) Salisbury, Maryland | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | 25a. REC'D BY REGISTRAR JAN 2 1968 25b. REGISTRAR'S SIGNATURE [Signature] | |

11831

11832

Mr. J. E. Carey
11831
11832
11833
11834
11835
11836
11837
11838
11839
11840
11841
11842
11843
11844
11845
11846
11847
11848
11849
11850
11851
11852
11853
11854
11855
11856
11857
11858
11859
11860
11861
11862
11863
11864
11865
11866
11867
11868
11869
11870
11871
11872
11873
11874
11875
11876
11877
11878
11879
11880
11881
11882
11883
11884
11885
11886
11887
11888
11889
11890
11891
11892
11893
11894
11895
11896
11897
11898
11899
11900
11901
11902
11903
11904
11905
11906
11907
11908
11909
11910
11911
11912
11913
11914
11915
11916
11917
11918
11919
11920
11921
11922
11923
11924
11925
11926
11927
11928
11929
11930
11931
11932
11933
11934
11935
11936
11937
11938
11939
11940
11941
11942
11943
11944
11945
11946
11947
11948
11949
11950
11951
11952
11953
11954
11955
11956
11957
11958
11959
11960
11961
11962
11963
11964
11965
11966
11967
11968
11969
11970
11971
11972
11973
11974
11975
11976
11977
11978
11979
11980
11981
11982
11983
11984
11985
11986
11987
11988
11989
11990
11991
11992
11993
11994
11995
11996
11997
11998
11999
12000

Mr. J. E. Carey
11831
11832
11833
11834
11835
11836
11837
11838
11839
11840
11841
11842
11843
11844
11845
11846
11847
11848
11849
11850
11851
11852
11853
11854
11855
11856
11857
11858
11859
11860
11861
11862
11863
11864
11865
11866
11867
11868
11869
11870
11871
11872
11873
11874
11875
11876
11877
11878
11879
11880
11881
11882
11883
11884
11885
11886
11887
11888
11889
11890
11891
11892
11893
11894
11895
11896
11897
11898
11899
11900
11901
11902
11903
11904
11905
11906
11907
11908
11909
11910
11911
11912
11913
11914
11915
11916
11917
11918
11919
11920
11921
11922
11923
11924
11925
11926
11927
11928
11929
11930
11931
11932
11933
11934
11935
11936
11937
11938
11939
11940
11941
11942
11943
11944
11945
11946
11947
11948
11949
11950
11951
11952
11953
11954
11955
11956
11957
11958
11959
11960
11961
11962
11963
11964
11965
11966
11967
11968
11969
11970
11971
11972
11973
11974
11975
11976
11977
11978
11979
11980
11981
11982
11983
11984
11985
11986
11987
11988
11989
11990
11991
11992
11993
11994
11995
11996
11997
11998
11999
12000

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17843

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN Tb <u>12 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> <u>22-1</u> d. STREET ADDRESS <u>314 GLEN AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>HERBERT STANLEY SCHAAB</u> First Middle Last 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/7/1903</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>64</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, RECEIVING CLK.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>BELTING MANUFACTURE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 4. DATE OF DEATH <u>DECEMBER 9</u> 19 <u>67</u> Month Day Year IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | | | | |
| 13. FATHER'S NAME <u>HENRY SCHAAB</u> 14. MOTHER'S MAIDEN NAME <u>MARY REMENTER</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> 17. INFORMANT <u>SHELDON SEIDEL, 110N. DIVISION ST</u> Address <u>SALISBURY</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>Arteriosclerotic Heart Disease</u> IMMEDIATE CAUSE (a) <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dissecting</u> (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Artemia</u> | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/7</u> , 19 <u>67</u> to <u>12/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/19</u> 19 <u>67</u> , and that death occurred at <u>11 P.M.</u> from causes and on the date stated above. | | | | | | | | 22a. SIGNATURE <u>David J. Gilmore</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>12/21/1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE, MD</u> | | | | 22d. ADDRESS <u>SALISBURY, MARYLAND</u> | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>12/22/1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON Cemetery</u> 23d. (City or town) (County) (State) <u>PHILADELPHIA, PA.</u> | |
| 24. FUNERAL DIRECTOR <u>Hill Funeral Home Salisbury, Md.</u> ADDRESS | | | | 25a. REC'D BY REGISTRAR <u>DEC 27 1967</u> | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS

1900

THE STATE OF TEXAS, COUNTY OF DALLAS, ss. I, the undersigned, Clerk of the County, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, State of Texas.

Witness my hand and seal of office at Dallas, Texas, this 1st day of January, 1900.

CLERK OF THE COUNTY OF DALLAS, TEXAS.

BY

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17839

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17844

CERTIFICATE OF DEATH

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 15 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 305 Middle Blvd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First BETTY Middle CHURCH Last SCHNEIDER | | 4. DATE OF DEATH Month DECEMBER Day 23 Year 19 67 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 3, 1908 |
| 9. AGE (In years last birthday) 59 yrs. | | 10. IF UNDER 1 YEAR Months 3 Days 26 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Registered Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY Nursing | |
| 11. BIRTHPLACE (County & State, or foreign country) N. Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Philip Gordon Church | | 14. MOTHER'S MAIDEN NAME Muter Minton | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT Reginald Schneider | | Address See #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemo thorax 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic carcinoma DUE TO (c) Breast carcinoma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 30 hrs 3 yrs 3 yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1964 to 12-23, 1967 that (I) (we) lost saw the deceased alive on 12-23, 1967 , and that death occurred at 4:58 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE O. D. Christensen, Sr. | | 22b. DATE SIGNED 12/26/67 | |
| 22c. PHYSICIAN'S NAME (Type) O. D. Christensen, Sr. | | 22d. ADDRESS S. Division St. Salisbury, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/26/1967 | 23c. NAME OF CEMETERY OR CREMATORY Wico. Mem. Park | 23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland |
| 24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland | | 25. REC'D BY REGISTRAR DATE DEC 28 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

EEBST

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17840

Item #7 Film #G396 12/27/67 ph

CERTIFICATE OF DEATH

17845

| | | | | | | | |
|--|------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY NOACESTEE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | | | d. STREET ADDRESS RFD 2 | | | |
| 3. NAME OF DECEASED (Type or print) First FRANK Middle JAMES Last SEARS | | | | 4. DATE OF DEATH Month DECEMBER Day 13 Year 1967 | | | |
| 5. SEX MALE | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAR. 9, 1888 | 9. AGE (In years last birthday) 79 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY BULLEY RAISER | | 11. BIRTHPLACE (County & State, or foreign country) SOUTH COVENTRY CONN | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME THOMAS J. SEARS | | | | 14. MOTHER'S MAIDEN NAME MARGARET STEWART | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 012-01-4589 | | 17. INFORMANT Address Mr. JAMES L. SEARS, Ossining N.Y. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral to bleed 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart failure DUE TO (c) Acute myocardial infarction | | | | | | INTERVAL BETWEEN ONSET AND DEATH 48 hours 48 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-12-67 , 19 67 , to 12-13-67 , 19 67 , that (I) (we) last saw the deceased alive on 12-13 , 19 67 , and that death occurred at 4:15 P.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Joseph C. Fitzgerald | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12-13-67 | |
| 22c. PHYSICIAN'S NAME (Type) Joseph C. Fitzgerald | | | | 22d. ADDRESS Medical Center, Salisbury, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 12/17/67 | | 23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS | | 23d. LOCATION (City or Town) (County) (State) BRATTLEBORO WIND. VT. | |
| 24. FUNERAL DIRECTOR James A. Prubage Berlin Md | | | | 25a. REC'D BY REGISTRAR DEC 18 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

03851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1544
30A REV. 7-68

17841
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

17846

| | | | | | | | | |
|--|---------|---|------------------|---|-------------------------------------|---|----------|---|
| 1. DECEASED-NAME (Type or print) | | First | Middle | Lost | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | |
| Albert | | - | | Shepherd | December 11 1967 | | 11 PM | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| Male | white | | Sept. 19, 1897 | | 70 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Washington, D.C. | | U.S.A. | | | | Wicomico Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Salisbury | | Pine Bluff State Hosp. | | painter | | - | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | Queen Anne's | | Millington | | | | |
| 14. FATHER'S NAME | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | First | Middle |
| Howard | | - | | Shepherd | Mary | | - | Mahugh |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Records of: Address | | |
| No | | 214-12-5582 | | Pine Bluff State Hospital | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor. Pulmonale</u> <u>002.1</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Tuberculosis</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>5 years</u> <u>7 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Dec. 9</u> , 19 <u>67</u> , to <u>Dec. 11</u> 19 <u>67</u> , that (X) (we) last saw the deceased alive on <u>Dec. 11</u> 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>E. P. Ritchings</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED <u>Dec. 12, 1967</u> | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | |
| E. P. Ritchings, M.D. | | Pine Bluff State Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| BURIAL | | DEC. 14 | | CRUMPTON | | CRUMPTON MARYLAND | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | |
| Edgar L. Lane | | Church Hill, Ind. | | DEC 18 1967 | | Charles Judge | | |

MEDICAL CERTIFICATION

17881

STATE OF DEATH

17881

17881

17881

17881

17881

17881

17881

17881

17881

17881

17881

17881

17881

17881

17881

17881

17881

17881

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17842

CERTIFICATE OF DEATH

17847

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route #6, Dagsboro Road</u> | | | | d. STREET ADDRESS <u>Rt. 6, Dagsboro Road</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>WADE</u> Last <u>SHOCKLEY</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>1967</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>August 11, 1899</u> | | 9. AGE (In years last birthday) <u>68</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Employee</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Pump Company</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Pittsville, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Emory Shockley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lavinia Figgs</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>215-18-4712A</u> | | 17. INFORMANT <u>Mrs. Helen M. Shockley (Wife)</u> <u>Rt. 6, Dagsboro Rd., Salisbury, Maryland</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis, Rt. Lung</u> DUE TO (b) <u>Chronic Obstructive Pulmonary Disease</u> DUE TO (c) <u>Carcinoma, Bronchogenic, Rt Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 mos 5 yrs 1 1/2 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Infection, Pulmonary, Chronic</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>62</u> to <u>DEC.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>DEC. (?)</u> 19 <u>67</u> , and that death occurred at <u>8:30</u> M. from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Professor R. S. Gardner Jr.</u> | | | | 22b. DATE SIGNED <u>12/24/67</u> | | 22c. PHYSICIAN'S NAME (Type) <u>RUBEN S. GARDNER JR</u> | |
| 22d. ADDRESS <u>MEDICAL CENTER, SALISBURY MD</u> | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Dec. 27, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u> | | | | 25a. REC'D BY REGISTRAR <u>DEC 28 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1785



NOV 20 1964

1785

RECEIVED

Form with multiple horizontal lines and faint text, likely a ledger or record book. The text is mostly illegible due to fading and bleed-through from the reverse side. Some faint words like "RECEIVED" and "NOV 20 1964" are visible at the top.

NOV 20 1964
RECEIVED
1785

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
20 M 1/68

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b Willards | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS -- | |
| 3. NAME OF DECEASED (Type or print) First LLOYD Middle L. Last Smith | | 4. DATE OF DEATH Month DECEMBER Day 27 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 17, 1897 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | |
| 11. BIRTHPLACE (County & State, or foreign country) Willards, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Asbury Smith | | 14. MOTHER'S MAIDEN NAME Charlotte Dennis | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-18-5789A | |
| 17. INFORMANT Mrs. Lula M. Smith (Wife) | | Address Willards, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 6000 DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Pyelonephritis DUE TO (c) Not known | | INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/18/67 to 12/27/67 that (I) (we) last saw the deceased alive on 12/26/67 and that death occurred at 1:45 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Dr. O. J. Burton | | 22b. DATE SIGNED December 27, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. O. J. Burton | | 22d. ADDRESS Medical Center, Salisbury, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 29, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Truitt Cemetery | | 23d. LOCATION (City or Town) (County) (State) Willards, Maryland | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | 25a. REC'D BY REGISTRAR DATE DEC 28 1967 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

61857

•

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17849

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>New Hanover</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u> d. STREET ADDRESS <u>715 Pine Grove Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>CHRISTENE</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>1967</u> | | 5. SEX <u>Female</u> | | | |
| 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 29, 1899</u> | | | |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Glouster, Maine</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>John Brown</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie - - - -</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>219-10-8559</u> | | 17. INFORMANT Address <u>Mr. Frank Barcus (Son) Wilmington 8, Delaware</u> <u>1800 Montclair Ave., Cranston Dr.,</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-12-1967</u> to <u>12-13-1967</u> that (I) (we) last saw the deceased alive on <u>12-13-1967</u> and that death occurred at <u>12:10 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Wilber R. Ellis, Jr.</u> | | 22b. DATE SIGNED <u>December 14/1967</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis, Jr.</u> | | | |
| 22d. ADDRESS <u>Medical Center, Salisbury, Maryland</u> | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Dec. 16, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u> | | | |
| 23d. LOCATION (City, town or county) <u>Wilmington, North Carolina</u> | | (State) | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u> | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |
| DATE <u>DEC 18 1967</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

WILLIAM & COMPANY, CALISBURY, MARYLAND

DEC 14 1887

DECEMBER 15 1887

WILLIAM & COMPANY, CALISBURY, MARYLAND

Dr. Walter R. Ellis, Jr.

Medical Center, Salisbury, Maryland

13:10
A.M.

WILLIAM & COMPANY, CALISBURY, MARYLAND

WILLIAM & COMPANY, CALISBURY, MARYLAND

WILLIAM & COMPANY, CALISBURY, MARYLAND

WILLIAM & COMPANY, CALISBURY, MARYLAND

WILLIAM & COMPANY, CALISBURY, MARYLAND

WILLIAM & COMPANY, CALISBURY, MARYLAND

WILLIAM & COMPANY, CALISBURY, MARYLAND

WILLIAM & COMPANY, CALISBURY, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Carolina b. COUNTY New Hanover | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS 715 Pine Grove Drive | |
| 3. NAME OF DECEASED (Type or print) First Middle Last GEORGE GOLEY SOMERSETT | | 4. DATE OF DEATH Month Day Year DECEMBER 15 19 67 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 11, 1911 |
| 9. AGE (In years last birthday) 55 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dredge Boat Captain | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Shallotte, N. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Somerset | | 14. MOTHER'S MAIDEN NAME Alice Bland | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 245-12-1359 | |
| 17. INFORMANT Mr. Frank Barcus (Step-son) | | Address 1800 Montclair Ave., Cranston Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver failure 3221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute + Chronic alcoholism, and DUE TO (c) pneumonia | | INTERVAL BETWEEN ONSET AND DEATH 2 years 3 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/24/1967 to 11/15/1967 , that (I) (we) last saw the deceased alive on 11/14/1967 , and that death occurred at 3:25 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Dr. O. J. Burton | | 22b. DATE SIGNED December 15, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. O. J. Burton | | 22d. ADDRESS Medical Center, Salisbury, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 16, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery | | 23d. LOCATION (City or Town) (County) (State) Wilmington, North Carolina | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | 25a. REC'D BY REGISTRAR DEC 18 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

17825

Albuquerque

11/1/1911

Location of animal in field

11/1/1911

11/1/1911

11/1/1911

11/1/1911

11/1/1911

11/1/1911

11/1/1911

11/1/1911

11/1/1911

11/1/1911

11/1/1911

11/1/1911

11/1/1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 8 & 9 Film G397 1/21/68 kk
17846
17901

| | | | | | | | |
|--|------------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Worcester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | | c. LENGTH OF STAY IN 1b SNOW HILL | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | | | d. STREET ADDRESS R.F.D. | | | |
| 3. NAME OF DECEASED (Type or print) John Stafford | | | | 4. DATE OF DEATH Month December Day 30 Year 1967 | | | |
| 5. SEX male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 13, 1907 | 9. AGE (In years last birthday) 60 yrs. | IF UNDER 1 YEAR Months 30 Days 19 Hours 67 | | IF UNDER 24 HRS. Hours 67 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY LABORER | | 11. BIRTHPLACE (County & State, or foreign country) ALA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Wesley Ramsey | | | | 14. MOTHER'S MAIDEN NAME Virginia Jackson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT BENJAMIN Ramsey Address 1726 E. 74th St. Chicago Ill | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic adenocarcinoma DUE TO (b) 5 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 1992 | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Generalized atherosclerosis | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/29 , 19 67 , to 12/30 , 19 67 , that (I) (we) last saw the deceased alive on 12/29 , 19 67 , and that death occurred at 4:30 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Earl Beardsley | | | | 22b. DATE SIGNED 12/30/67 | | | |
| 22c. PHYSICIAN'S NAME (Type) Earl Beardsley | | | | 22d. ADDRESS MARYLAND Ave. Salisbury, Wicomico, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 1-4-68 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Baptist | | 23d. LOCATION (City or Town) (County) (State) SNOW HILL Woco. Md. | |
| 24. FUNERAL DIRECTOR Loretta B. Jolley Jersey Rd. #2 Salisbury, Md. | | | | 25a. REC'D BY REGISTRAR J. Charles Jones | | 25b. REGISTRAR'S SIGNATURE J. Charles Jones | |
| | | | | DATE JAN 12 1968 | | | |

10051

Notes taken at Cambridge 27.2.

James G. Thompson

[Faint handwritten notes at the bottom of the page, possibly indicating dates or initials.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 2,503 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Martha Middle Edna Last Strong | | 4. DATE OF DEATH Month December Day 1 Year 19 67 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 4, 1876 |
| 9. AGE (In years last birthday) 91 yrs. | | 10. IF UNDER 1 YEAR Months 14 Days 2 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Kent Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME T. Romie Strong | | 14. MOTHER'S MAIDEN NAME Charlotte Wickes | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 215 36 0635 | |
| 17. INFORMANT A. - Charlotte Jacquette | | Address (Rock Hall Maryland) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart Parkinsonism | | | INTERVAL BETWEEN ONSET AND DEATH 1 hr. Years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that it (this hospital) attended the deceased from 1/23 , 19 61 , to 12/1 , 19 67 , that he (we) last saw the deceased alive on 12/1 , 19 67 , and that death occurred at 1:10 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE A. C. Mitchell, M.D. | | 22b. DATE SIGNED 12/1/67 | |
| 22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D. | | 22d. ADDRESS Deer's Head State Hospital; Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/3/67 | 23c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery | 23d. LOCATION (City or Town) (County) (State) near Chestertown, Md. |
| 24. FUNERAL DIRECTOR Wells Wells | | 25a. REC'D BY REGISTRAR DEC 5 1967 | |
| ADDRESS Chestertown, Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

17881

17881

17881

17881

17881

17881

X

17881

17881

17881

17881

17881

17881

17881

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 22-7 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS Headquarters Fire Co. S. Division Street | |
| 3. NAME OF DECEASED (Type or print) First MARION Middle SLEMONS (ROCK) Last TAYLOR | | 4. DATE OF DEATH Month December Day 3 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 4, 1884 |
| 9. AGE (In years last birthday) yrs. 83 | | IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Painter | | 10b. KIND OF BUSINESS OR INDUSTRY Wicomico County, Maryland | |
| 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John D. Taylor | | 14. MOTHER'S MAIDEN NAME Emma Ennis | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown | | 16. SOCIAL SECURITY NO. 212-18-6384A | |
| 17. INFORMANT Chief Wilson Taylor Salisbury Fire Dept., Salisbury, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201 DUE TO Coronary occlusion (c) 4201 DUE TO Coronary occlusion | | INTERVAL BETWEEN ONSET AND DEATH 4201 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Earl L. Royer M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED December 5 / 1967 | |
| Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 6, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | | 23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND | | 25a. REC'D BY REGISTRAR DEC 7 1967 | |
| 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

John

James

W. H. H.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|---------------------------|--|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne | |
| c. LENGTH OF STAY IN b. Life Time | | d. STREET ADDRESS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mary Anne Thomas | | 4. DATE OF DEATH Month Day Year 12-2-67 19 | |
| 5. SEX F | 6. COLOR OR RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-26-67 |
| 9. AGE (In years last birthday) yrs. 7 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Clarence Thomas | | 14. MOTHER'S MAIDEN NAME Elsie Andersen | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Clarence Thomas, Princess Anne, Md | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7545 IMMEDIATE CAUSE (a) Congenital Heart malformation. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH initial | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Sudden Death In Infancy | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Earl L. Boyer, M.D. EXAMINER'S NAME (Type) | | 22. DATE SIGNED 12-4-67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/5/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mt Zion | | 23d. LOCATION (City or Town) (County) (State) Polk Road, Md | |
| 24. FUNERAL DIRECTOR William H. James Jr. Princess Anne, Md | | 25a. REC'D BY REGISTRAR DEC 11 1967 | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

7-240209

Inflected H. longicauda

[Handwritten signature]

• • •

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

17850

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G396 12/20/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17854

| | | | | | | | |
|--|----------------------------------|---|------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | | | d. STREET ADDRESS Route # 2 | | | |
| 3. NAME OF DECEASED (Type or print) First Dockey Y Middle Thompson Last | | | | 4. DATE OF DEATH Month 12 Day 8 Year 67 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-20-03 | 9. AGE (In years last birthday) 64 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farmer | | 11. BIRTHPLACE (State or foreign country) Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Harvey Thompson | | | | 14. MOTHER'S MAIDEN NAME Nannie Shackelford | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — | | 16. SOCIAL SECURITY NO. 215-20-0040 | | 17. INFORMANT Herman Brooks Salisbury, Md. R3 2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Years | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Earl L. Royer, M.D. | | EXAMINER'S NAME (Type) Earl L. Royer, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED 12-10-67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/10/67 | | 23c. NAME OF CEMETERY OR CREMATORY H. Stephens Corn Park | | 23d. LOCATION (City or Town) (County) (State) Delmar Sussex Del | |
| 24. FUNERAL DIRECTOR Marvel Funeral Home Delmar, Del. | | | | 25a. REC'D BY REGISTRAR DEC 15 1967 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

1957
100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17851

17855

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Accomack ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Church, VA. P3.3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS New Church, VA | |
| 3. NAME OF DECEASED (Type or print) First Lillie Middle A. Last TRADER | | 4. DATE OF DEATH Month DECEMBER Day 16 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/8/1881 |
| 9. AGE (In years last birthday) 86 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 10b. KIND OF BUSINESS OR INDUSTRY Seamstress | |
| 11. BIRTHPLACE (County & State, or foreign country) ATLANTIC | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John W. Watson | | 14. MOTHER'S MAIDEN NAME Mary Thornton | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 223-18-6891 | |
| 17. INFORMANT Will Bladding, New Church, VA. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest. 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right hemiparesis DUE TO (c) ASCVD | | | INTERVAL BETWEEN ONSET AND DEATH 5 days. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12-12-67 , 19 67 to 12-16-67 , 19 67 , that (I) (we) last saw the deceased alive on 12-16 , 19 67 , and that death occurred at 7:45 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Joseph C. Fitzgerald | | 22b. DATE SIGNED 12-17-67 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/19/67 | 23c. NAME OF CEMETERY OR CREMATORY Nelson's Ceme | 23d. LOCATION (City or Town) (County) (State) New Church Accomack VA |
| 24. FUNERAL DIRECTOR James N. Fat Imperanceville, VA | | 25a. REC'D BY REGISTRAR DEC 21 1967 | 25b. REGISTRAR'S SIGNATURE James N. Fat |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1525

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17852

CERTIFICATE OF DEATH

17856

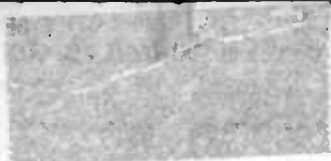
| | | | | | | | |
|--|--|---|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRANKFORD</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Paris</u> Middle <u>Truitt</u> Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 4. DATE OF DEATH <u>December</u> Month <u>29</u> Day <u>19</u> Year <u>67</u> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAIL CARRIER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>William E. Truitt</u> | | | 14. MOTHER'S MAIDEN NAME <u>Parisene Truitt</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>017-26-4318</u> | | 17. INFORMANT Address <u>Wm. A. Truitt, Frankford, Del.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute myocardial infarction</u> DUE TO (c) <u>Coronary atherosclerosis</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 hrs</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from <u>10-29-67</u> , to <u>12-29-67</u> , that (I) (we) last saw the deceased alive on <u>12-29-1967</u> , and that death occurred at <u>11:30</u> P.M., from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>James L. Clifford</u> | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>12-29-67</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>James L. Clifford</u> | | | 22d. ADDRESS <u>Medical Center Salisbury, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>1-2-68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>CAREY'S CEMETERY FRANKFORD, SUSSEX, DEL.</u> | | | |
| 23d. LOCATION (City or Town) (County) (State) 24. FUNERAL DIRECTOR <u>A. Douglas Nelson, Frankford, Del.</u> | | 25a. REC'D BY REGISTRAR DATE <u>JAN 3 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1555

CERTIFICATE OF DEATH



1555

1555

1555

1555

1555

1555

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS 1103 Lake Street | |
| 3. NAME OF DECEASED (Type or print) First Elwood Middle Charles Last Tull | | 4. DATE OF DEATH Month 12 Day 17 Year 1967 | |
| 5. SEX M | 6. COLOR OR RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1911 |
| 9. AGE (In years (by birthday) yrs. 56 | | 10. IF UNDER 1 YEAR Months 12 Days 17 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY BARBER | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Tull | | 14. MOTHER'S MAIDEN NAME ANNIE BOSTON | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT HENRY TULL | | Address — | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound of brain 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 40 min. |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during a domestic quarrel. |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:30 a.m. 12-17-67 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home |
| 20f. (City or town) Oriole | | (County) (State) Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Earl L. Royer | | M.D. | |
| EXAMINER'S NAME (Type) Earl L. Royer, M.D. | | 22. DATE SIGNED 12-18-67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 12/22/67 | | 23b. DATE THEREOF 12/22/67 | |
| 23c. NAME OF CEMETERY OR CREMATORIUM Greenwood Cemetery | | 23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Md. | |
| 24. FUNERAL DIRECTOR Booker West Funeral Home, Salisbury, Md. | | 25a. REC'D BY REGISTRAR DEC 27 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

1785

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17854

17858

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela | | c. LENGTH OF STAY IN TB 5 Yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maple Shade Nursing Home | | d. STREET ADDRESS 3016 Alisa Ave., | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Louise | | 4. DATE OF DEATH Month 12 Day 14 Year 1967 | |
| 5. SEX Female | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7-26-1890 | |
| 9. AGE (In years last birthday) 77 yrs. | | 10. IF UNDER 1 YEAR Months 77 Days 77 | |
| 11. IF UNDER 24 HRS. Hours 77 Min. 77 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Work | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Clay Tull | | 14. MOTHER'S MAIDEN NAME Margaret Elizabeth Ross | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Richard M. Dahlstrom Salisbury, Md. | | Address 108 White St., | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Arterio Sclerosis 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH 104 m. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1967 to 12/14 , 19 67 , that (I) (we) last saw the deceased alive on 12/14 , 19 67 , and that death occurred at 5:10 P M, from causes and on the date stated above | | | |
| 22a. SIGNATURE H. S. Kuhlman | | 22b. DATE SIGNED 12-15-1967 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. H. S. Kuhlman | | 22d. ADDRESS Sharptown, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-17-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Nelson Cemetery | | 23d. LOCATION (City or Town) (County) (State) New Church, Va. | |
| 24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland | | 25a. RECD BY REGISTRAR DEC 21 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

22354

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17855

17859

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 236 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital | | d. STREET ADDRESS Calvary Road | |
| 3. NAME OF DECEASED (Type or print) KATTIE JANE TYLER | | 4. DATE OF DEATH Month Dec. Day 17 Year 19 67 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 22, 1885 |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR Months 82 Days 17 Hours 19 Min. | IF UNDER 24 HRS. Hours 19 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 10b. KIND OF BUSINESS OR INDUSTRY Clothing Mfg. | 11. BIRTHPLACE (County & State, or foreign country) Crisfield, Md. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME William Tyler | |
| 14. MOTHER'S MAIDEN NAME Sarah Lawson | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 217-01-4649 | | 17. INFORMANT R.F.D. Box 288 Harold Howard, Sr. - Crisfield, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks Years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Apr. 25 , 19 67 , to Dec. 17 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 17 , 19 67 , and that death occurred at 6:45 A.M. M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE L. V. Maldve | | 22b. DATE SIGNED 12/17/67 | |
| 22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. | | 22d. ADDRESS Deer's Head Hospital; Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 19, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery | | 23d. LOCATION (City or Town) (County) (State) Crisfield, Md. | |
| 24. FUNERAL DIRECTOR Levin R. Wilson - Somerset County, Md. | | 25a. REC'D BY REGISTRAR DEC 21 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

1955

DEPARTMENT OF HEALTH

1955

Oct. 2, 1955

17-1-149

1955 - 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17860

| | | | |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Delaware b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Selbyville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS Route # 1 | |
| 3. NAME OF DECEASED (Type or print) First Clay Middle Elmer Last Sr. Waite, Jr. | | 4. DATE OF DEATH Month 12 Day 25 Year 1967 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 24, 1930 |
| 9. AGE (In years lost birthday) yrs. 37 | | IF UNDER 1 YEAR Months 0 Oys 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance | | 10b. KIND OF BUSINESS OR INDUSTRY Factory | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U S | |
| 13. FATHER'S NAME Elmer Waite | | 14. MOTHER'S MAIDEN NAME Catherine Evans | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 215-26-4575 | | 16. SOCIAL SECURITY NO. 215-26-4575 | |
| 17. INFORMANT Julia Waite | | Address Selbyville, Del. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute alcoholism 3220 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH R D # 1 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? X YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md. | | 22. DATE SIGNED 12-26-67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-29-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Lakeside | | 23d. LOCATION (City or Town) (County) (State) Dover, Kent Del. | |
| 24. FUNERAL DIRECTOR William J. Warwick Funeral Home NEWARK | | 25a. REC'D BY REGISTRAR DATE JAN 2 1968 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

13554

Michigan
Saginaw
Saginaw

Michigan

Michigan

Michigan

13554

Michigan

Michigan

Michigan

13554

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

Michigan

[Handwritten signature]

Michigan

13554

Michigan

13554

Michigan

Michigan

Michigan

Michigan

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 File #G396 12/20/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17857

17861

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|------------------------------|---|--------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland | | | | c. LENGTH OF STAY IN It | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lottie Forbes Nursing Home | | | | d. STREET ADDRESS Manokin | | | |
| 3. NAME OF DECEASED (Type or print) First Henrietta Middle Ward Last Ward | | | | 4. DATE OF DEATH Month 12 Day 2 Year 67 | | | |
| 5. SEX F | 6. COLOR OR RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-4-1892 | 9. AGE (In years lost birthday) yrs. 75 | IF UNDER 1 YEAR Months 19 Days 2 Hours 19 Min. | | IF UNDER 24 HRS. Hours 19 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Fairmount, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Ward | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Anna J. Madder Address Manokin, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C.V. Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Earl L. Royer, M.D. 409 Camden Ave. Salisbury, Md. | | | | 22. DATE SIGNED 12-4-67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 12-5-67 | | 23c. NAME OF CEMETERY OR CREMATORY Samuel Wesley | | 23d. LOCATION (City or town) (County) (State) Manokin Somerset, Md. | |
| 24. FUNERAL DIRECTOR William J. James II 258 Church St. Princess Anne, Md. | | | | 25a. REC'D BY REGISTRAR DEC 12 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

17057



John C. ...
...

...
...

12-1-57

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/50

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 22-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 519 Rose St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Bertha L. Washington | | 4. DATE OF DEATH Month 12 Day 31 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE C. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/16/1909 |
| 9. AGE (In years last birthday) 58 yrs. | | 10. IF UNDER 1 YEAR Months 12 Days 31 Hours 19 Min. 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Dashiell | | 14. MOTHER'S MAIDEN NAME Annabelle ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Anne Easley 519 Rose St. Salis Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) arteriosclerotic cardiovascular disease DUE TO (c) myocardial ischemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs 10 mos |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) exogenous obesity | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12/8/67 , 19 67 , to 12/31/67 , 19 67 , that (I) (we) last saw the deceased alive on 12/30 , 19 67 , and that death occurred at 5 M, from causes and on the date stated above | | | |
| 22a. SIGNATURE Alberta Polin | | 22b. DATE SIGNED 1/2/68 | |
| 22c. PHYSICIAN'S NAME (Type) Alberta Mattax Polin | | 22d. ADDRESS 707 Camden Avenue, Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 1/4/1968 | 23c. NAME OF CEMETERY OR CREMATORY Green Acres | 23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico Md. |
| 24. FUNERAL DIRECTOR Phyllis F. Stewart Salis Md. | | 25a. REC'D BY REGISTRAR JAN 8 1968 DATE | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Jones | |

12/18/47
12/12/47
12/10/47
12/8/47
12/6/47
12/4/47
12/2/47
12/1/47
11/29/47
11/27/47
11/25/47
11/23/47
11/21/47
11/19/47
11/17/47
11/15/47
11/13/47
11/11/47
11/9/47
11/7/47
11/5/47
11/3/47
11/1/47
10/30/47
10/28/47
10/26/47
10/24/47
10/22/47
10/20/47
10/18/47
10/16/47
10/14/47
10/12/47
10/10/47
10/8/47
10/6/47
10/4/47
10/2/47
9/30/47
9/28/47
9/26/47
9/24/47
9/22/47
9/20/47
9/18/47
9/16/47
9/14/47
9/12/47
9/10/47
9/8/47
9/6/47
9/4/47
9/2/47
8/31/47
8/29/47
8/27/47
8/25/47
8/23/47
8/21/47
8/19/47
8/17/47
8/15/47
8/13/47
8/11/47
8/9/47
8/7/47
8/5/47
8/3/47
8/1/47
7/30/47
7/28/47
7/26/47
7/24/47
7/22/47
7/20/47
7/18/47
7/16/47
7/14/47
7/12/47
7/10/47
7/8/47
7/6/47
7/4/47
7/2/47
6/30/47
6/28/47
6/26/47
6/24/47
6/22/47
6/20/47
6/18/47
6/16/47
6/14/47
6/12/47
6/10/47
6/8/47
6/6/47
6/4/47
6/2/47
5/31/47
5/29/47
5/27/47
5/25/47
5/23/47
5/21/47
5/19/47
5/17/47
5/15/47
5/13/47
5/11/47
5/9/47
5/7/47
5/5/47
5/3/47
5/1/47
4/30/47
4/28/47
4/26/47
4/24/47
4/22/47
4/20/47
4/18/47
4/16/47
4/14/47
4/12/47
4/10/47
4/8/47
4/6/47
4/4/47
4/2/47
3/31/47
3/29/47
3/27/47
3/25/47
3/23/47
3/21/47
3/19/47
3/17/47
3/15/47
3/13/47
3/11/47
3/9/47
3/7/47
3/5/47
3/3/47
3/1/47
2/28/47
2/26/47
2/24/47
2/22/47
2/20/47
2/18/47
2/16/47
2/14/47
2/12/47
2/10/47
2/8/47
2/6/47
2/4/47
2/2/47
1/31/47
1/29/47
1/27/47
1/25/47
1/23/47
1/21/47
1/19/47
1/17/47
1/15/47
1/13/47
1/11/47
1/9/47
1/7/47
1/5/47
1/3/47
1/1/47
12/30/46
12/28/46
12/26/46
12/24/46
12/22/46
12/20/46
12/18/46
12/16/46
12/14/46
12/12/46
12/10/46
12/8/46
12/6/46
12/4/46
12/2/46
11/30/46
11/28/46
11/26/46
11/24/46
11/22/46
11/20/46
11/18/46
11/16/46
11/14/46
11/12/46
11/10/46
11/8/46
11/6/46
11/4/46
11/2/46
10/31/46
10/29/46
10/27/46
10/25/46
10/23/46
10/21/46
10/19/46
10/17/46
10/15/46
10/13/46
10/11/46
10/9/46
10/7/46
10/5/46
10/3/46
10/1/46
9/30/46
9/28/46
9/26/46
9/24/46
9/22/46
9/20/46
9/18/46
9/16/46
9/14/46
9/12/46
9/10/46
9/8/46
9/6/46
9/4/46
9/2/46
8/31/46
8/29/46
8/27/46
8/25/46
8/23/46
8/21/46
8/19/46
8/17/46
8/15/46
8/13/46
8/11/46
8/9/46
8/7/46
8/5/46
8/3/46
8/1/46
7/30/46
7/28/46
7/26/46
7/24/46
7/22/46
7/20/46
7/18/46
7/16/46
7/14/46
7/12/46
7/10/46
7/8/46
7/6/46
7/4/46
7/2/46
6/30/46
6/28/46
6/26/46
6/24/46
6/22/46
6/20/46
6/18/46
6/16/46
6/14/46
6/12/46
6/10/46
6/8/46
6/6/46
6/4/46
6/2/46
5/31/46
5/29/46
5/27/46
5/25/46
5/23/46
5/21/46
5/19/46
5/17/46
5/15/46
5/13/46
5/11/46
5/9/46
5/7/46
5/5/46
5/3/46
5/1/46
4/30/46
4/28/46
4/26/46
4/24/46
4/22/46
4/20/46
4/18/46
4/16/46
4/14/46
4/12/46
4/10/46
4/8/46
4/6/46
4/4/46
4/2/46
3/31/46
3/29/46
3/27/46
3/25/46
3/23/46
3/21/46
3/19/46
3/17/46
3/15/46
3/13/46
3/11/46
3/9/46
3/7/46
3/5/46
3/3/46
3/1/46
2/28/46
2/26/46
2/24/46
2/22/46
2/20/46
2/18/46
2/16/46
2/14/46
2/12/46
2/10/46
2/8/46
2/6/46
2/4/46
2/2/46
1/31/46
1/29/46
1/27/46
1/25/46
1/23/46
1/21/46
1/19/46
1/17/46
1/15/46
1/13/46
1/11/46
1/9/46
1/7/46
1/5/46
1/3/46
1/1/46
12/30/45
12/28/45
12/26/45
12/24/45
12/22/45
12/20/45
12/18/45
12/16/45
12/14/45
12/12/45
12/10/45
12/8/45
12/6/45
12/4/45
12/2/45
11/30/45
11/28/45
11/26/45
11/24/45
11/22/45
11/20/45
11/18/45
11/16/45
11/14/45
11/12/45
11/10/45
11/8/45
11/6/45
11/4/45
11/2/45
10/31/45
10/29/45
10/27/45
10/25/45
10/23/45
10/21/45
10/19/45
10/17/45
10/15/45
10/13/45
10/11/45
10/9/45
10/7/45
10/5/45
10/3/45
10/1/45
9/30/45
9/28/45
9/26/45
9/24/45
9/22/45
9/20/45
9/18/45
9/16/45
9/14/45
9/12/45
9/10/45
9/8/45
9/6/45
9/4/45
9/2/45
8/31/45
8/29/45
8/27/45
8/25/45
8/23/45
8/21/45
8/19/45
8/17/45
8/15/45
8/13/45
8/11/45
8/9/45
8/7/45
8/5/45
8/3/45
8/1/45
7/30/45
7/28/45
7/26/45
7/24/45
7/22/45
7/20/45
7/18/45
7/16/45
7/14/45
7/12/45
7/10/45
7/8/45
7/6/45
7/4/45
7/2/45
6/30/45
6/28/45
6/26/45
6/

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17859

CERTIFICATE OF DEATH

17863

| | | | | | | | | |
|---|--|---|-------------------------|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital D.O.A.</u> | | | | d. STREET ADDRESS <u>204 Brooklyn Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>BARCLAY HEARNE Wheatley</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>12</u> Year <u>1967</u> | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 22, 1903</u> | | |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction worker</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester County, Maryland</u> | | |
| 13. FATHER'S NAME <u>George Elmer (Hicks) Wheatley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Georgia Louise Ellis</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-07-7759</u> | | 17. INFORMANT Address <u>Mrs. Blanche C. Wheatley (Wife)</u> <u>204 Brooklyn Ave., Salisbury, Md.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>12 day</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-12, 1967</u> , to <u>12-12, 1967</u> , that (I) (we) last saw the deceased alive on <u>12-12, 1967</u> , and that death occurred at <u>7:12 M.</u> from causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE <u>Wilber R. Ellis, Jr.</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>12-12-67</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis, Jr.</u> | | | | 22d. ADDRESS <u>Medical Center, Salisbury, Maryland</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Dec. 15, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Galestown Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Galestown, Maryland</u> | | |
| 24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>DEC 15 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17828

UNITED STATES DEPARTMENT OF AGRICULTURE

1902

Blank form with horizontal lines and a central vertical line, typical of a survey or record sheet.

Vertical text on the right margin, likely a title or description, partially obscured by a large black dot.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

80

MEDICAL CERTIFICATION

3

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

17860

17864

| | | | | | | | |
|---|--|--|-------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE HAVEN 22-1 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Dora Middle R. Last Williams | | | | 4. DATE OF DEATH December 27 19 67 Month Day Year | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH MARCH 3, 1900 | |
| 9. AGE (In years last birthday) 67 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) ORIOLE, MD. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME ROBERT ROSS | | | |
| 14. MOTHER'S MAIDEN NAME REBECCA DAVIS. | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT FRANK C. WILLIAMS Address WHITE HAVEN, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma colon DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 mo 6 mo |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11-25 , 19 67 , to 12-27 , 19 67 , that (I) (we) last saw the deceased alive on 12-27 , 19 67 , and that death occurred at 6:30 A.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>[Signature]</i> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12-28-67 | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 12/29/1967 | | 23c. NAME OF CEMETERY OR CREMATORY ORIOLE CEMETERY | | 23d. LOCATION (City or Town) (County) (State) ORIOLE, MARYLAND | |
| 24. FUNERAL DIRECTOR LEVIN R. WILSON ADDRESS PRINCESS, MARYLAND | | | | 25a. REC'D BY REGISTRAR DATE JAN 2 1968 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

1786

CERTIFICATE OF DEATH

1786

MARYLAND

MARYLAND

WHITE HAVEN

WHITE HAVEN

DEATH OF

1786

1786

1786

1786

1786

1786

1786

1786

1786

1786

1786

1786

1786

1786

1786

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

80

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 1 week | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS P. O. Box 54 | |
| 3. NAME OF DECEASED (Type or print) First CATHRYN Middle ISABELLE Last Wilson | | 4. DATE OF DEATH December 27 19 67 | |
| 5. SEX FEMALE | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 28, 1904 |
| 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR Months Days Hours Mm. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY Medical | |
| 11. BIRTHPLACE (County & State, or foreign country) Willis Wharf, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Ira Stuart Holland | | 14. MOTHER'S MAIDEN NAME Bessie Adams | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-30-8804 | |
| 17. INFORMANT Carl A. Wilson, Sr., same as 2.abcd | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Necrotizing Pneumonia 5870 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 2 P. M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Richard E. Hughes | | 22b. DATE SIGNED 1/2/68 | |
| 22c. PHYSICIAN'S NAME (Type) Richard E. Hughes, M.D. | | 22d. ADDRESS Medical Center - Salisbury, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 30, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery | | 23d. LOCATION (City or Town) (County) (State) Marion Station, Md. | |
| 24. FUNERAL DIRECTOR Levin R. Wilson - Somerset County, Md. | | 25a. REC'D BY REGISTRAR JAN 8 1968 | |
| 25b. REGISTRAR'S SIGNATURE Richard E. Hughes | | | |

17861

RECEIVED OF

17861

RECEIVED

RECEIVED

17861

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

RECEIVED OF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div>1</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>17862</div> <div>17866</div> | | | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wicomico Nursing Home | | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 204 Marshall Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) Jessie Ellen Wootten First Middle Last 4. DATE OF DEATH Dec. 22, 1967 Month Day Year | | | | | 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 16, 1909 last birthday yrs. Months Days Hours Min. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teller 10b. KIND OF BUSINESS OR INDUSTRY Bank | | | | | 9. AGE (In years last birthday) 58 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | |
| 13. FATHER'S NAME George Parker 14. MOTHER'S MAIDEN NAME Annie Warren | | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 218-20-5974 17. INFORMANT Mr. N.H. Wootten Address Same as #2 | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) generalized carcinomatosis DUE TO (b) Carcinoma of colon. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/21/67 to 12/22/67 , that (I) (we) last saw the deceased alive on 12/21/67 , and that death occurred at 5 A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Paula Bandy M.D. 22c. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22b. DATE SIGNED 12/22/67 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12-24-1967 23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery 23d. LOCATION (City, town or county) (State) Salisbury, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Thomas F. Wallace ADDRESS Salisbury, Md. 25a. REC'D BY REGISTRAR DEC 27 1967 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

1883

CENTRAL CO. OF CALIF.

1883

1

For the year ending 1883
Balance 7/1/83

1883
1883
1883

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
1
2

17863

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 4 & 21 Film G397 2/19/68 Wk

CERTIFICATE OF DEATH

17867

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | | c. LENGTH OF STAY in 1b 1Yr. 3Mos. 23Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital | | | | d. STREET ADDRESS 403 Chestnut | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Mary MADELINE M. Wootten | | | | 4. DATE OF DEATH December 30 31 19 67 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH MAY 29 1897 | |
| 9. AGE (In years last birthday) 70 yrs. | | 10. IF UNDER 1 YEAR Months Days | | 11. IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (County & State, or foreign country) SUSSEX, DELAWARE | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME FRANKLIN MARVEL | | | | 14. MOTHER'S MAIDEN NAME ANNIE MILLIGAN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Address Hospital Records | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Heart Disease DUE TO (c) Subarachnoid Hemorrhage - Right | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 Hrs. Years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 9/8/66 , 19__ to 12/30/67 , 19__, that (I) (we) last saw the deceased alive on 12/30/67 , 19__, and that death occurred at 12:00 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Charles H. Winnacott M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12/30/67 | |
| 22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott, M. D. | | | | 22d. ADDRESS Box 2018, Salisbury, Md. - 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| BURIAL | | JAN 2, 1968 | | ODD FELLOWS CEM. | | SEAFORD SUSSEX DEL | |
| 24. FUNERAL DIRECTOR Rayner M. Watson | | | | ADDRESS SEAFORD DEL. | | 25a. REC'D BY REGISTRAR JAN 3 1968 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

17883

17883

17883

17883

17883

17883

17883

17883

17883

17883

17883

17883

17883

17883

17883

17883

17883

17883

17883

17883

17883

17883

17883

17883